shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for the fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year. Any such grant to a State, which shall not exceed 75 per centum of the cost of the planning and related activities involved, may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

(Aug. 14, 1935, ch. 531, title XVII, § 1702, as added Pub. L. 88–156, § 5, Oct. 24, 1963, 77 Stat. 275; amended Pub. L. 89–97, title II, § 211(b), July 30, 1965, 79 Stat. 356.)

Editorial Notes

AMENDMENTS

1965—Pub. L. 89–97 inserted provision making appropriations for fiscal year ending June 30, 1966, available for grants during such fiscal year and the next two fiscal years and the appropriation for fiscal year ending June 30, 1967, available for grants during such fiscal year and the succeeding fiscal year.

§ 1393. Applications; single State agency designation; essential planning services; plans for expenditure; final activities report and other necessary reports; records; accounting

In order to be eligible for a grant under section 1392 of this title, a State must submit an application therefor which—

(1) designates or establishes a single State agency, which may be an interdepartmental agency, as the sole agency for carrying out the purposes of this subchapter;

(2) indicates the manner in which provision will be made to assure full consideration of all aspects of services essential to planning for comprehensive State and community action to combat mental retardation, including services in the fields of education, employment, rehabilitation, welfare, health, and the law, and services provided through community programs for and institutions for the mentally retarded;

(3) sets forth its plans for expenditure of such grant, which plans provide reasonable assurance of carrying out the purposes of this subchapter;

(4) provides for submission of a final report of the activities of the State agency in carrying out the purposes of this subchapter, and for submission of such other reports, in such form and containing such information, as the Secretary may from time to time find necessary for carrying out the purposes of this subchapter and for keeping such records and affording such access thereto as he may find necessary to assure the correctness and verification of such reports; and

(5) provides for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subchapter.

(Aug. 14, 1935, ch. 531, title XVII, § 1703, as added Pub. L. 88–156, § 5, Oct. 24, 1963, 77 Stat. 275.)

§ 1394. Payments to States; adjustments; advances or reimbursement; installments; conditions

Payment of grants under this subchapter may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine.

(Aug. 14, 1935, ch. 531, title XVII, § 1704, as added Pub. L. 88–156, § 5, Oct. 24, 1963, 77 Stat. 276.)

SUBCHAPTER XVIII—HEALTH INSURANCE FOR AGED AND DISABLED

Executive Documents

EX. ORD. NO. 13890. PROTECTING AND IMPROVING MEDICARE FOR OUR NATION'S SENIORS

Ex. Ord. No. 13890, Oct. 3, 2019, 84 F.R. 53573, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. The proposed Medicare for All Act of 2019, as introduced in the Senate [S. 1129, 116th Congress, 1st Session] (''Medicare for All'') would destroy our current Medicare program, which enables our Nation's seniors and other vulnerable Americans to receive affordable, high-quality care from providers of their choice. Rather than upend Medicare as we know it, my Administration will protect and improve it.

America's seniors are overwhelmingly satisfied with their Medicare coverage. The vast majority of seniors believe that the program delivers high-quality health outcomes. Medicare empowers seniors to choose their own providers and the type of health insurance that works best for them, whether it is fee-for-service (FFS) Medicare, in which the Federal Government pays for covered services, or Medicare Advantage (MA), in which Medicare dollars are used to purchase qualified private health insurance. ''Medicare for All'' would take away the choices currently available within Medicare and centralize even more power in Washington, harming seniors and other Medicare beneficiaries. Throughout their lives, workers and their employers have contributed their own money to the Medicare Trust Fund. It would be a mistake to eliminate Americans' healthcare choices and to force them into a new system that is effectively a Government takeover of their healthcare.

''Medicare for All'' would not only hurt America's seniors, it would also eliminate health choices for all Americans. Instead of picking the health insurance that best meets their needs, Americans would generally be subject to a single, Government-run system. Private insurance for traditional health services, upon which millions of Americans depend, would be prohibited. States would be hindered from offering the types of insurance that work best for their citizens. The Secretary of Health and Human Services (Secretary) would have the authority to control and approve health expenditures; such a system could create, among other problems, delays for patients in receiving needed care. To pay for this system, the Federal Government would compel Americans to pay more in taxes. No one—neither seniors nor any American—would have the same options to choose their health coverage as they do now.

Instead of ending the current Medicare program and eliminating health choices for all Americans, my Administration will continue to protect and improve

Medicare by building on those aspects of the program that work well, including the market-based approaches in the current system. The MA component, for example, delivers efficient and value-based care through choice and private competition, and has improved aspects of the Medicare program that previously failed seniors. The Medicare program shall adopt and implement those market-based recommendations developed pursuant to Executive Order 13813 of October 12, 2017 (Promoting Healthcare Choice and Competition Across the United States) [42 U.S.C. 18001 note], and published in my Administration's report on ''Reforming America's Healthcare System Through Choice and Competition.'' Doing so would help empower patients to select and access the right care, at the right time, in the right place, from the right provider.

SEC. 2. *Policy*. It is the policy of the United States to protect and improve the Medicare program by enhancing its fiscal sustainability through alternative payment methodologies that link payment to value, increase choice, and lower regulatory burdens imposed upon providers.

SEC. 3. *Providing More Plan Choices to Seniors*. (a) Within 1 year of the date of this order [Oct. 3, 2019], the Secretary shall propose a regulation and implement other administrative actions to enable the Medicare program to provide beneficiaries with more diverse and affordable plan choices. The proposed actions shall:

(i) encourage innovative MA benefit structures and plan designs, including through changes in regulations and guidance that reduce barriers to obtaining Medicare Medical Savings Accounts and that promote innovations in supplemental benefits and telehealth services;

(ii) include a payment model that adjusts supplemental MA benefits to allow Medicare beneficiaries to share more directly in the savings from the program, including through cash or monetary rebates, thus creating more incentives to seek high-value care; and

(iii) ensure that, to the extent permitted by law, FFS Medicare is not advantaged or promoted over MA with respect to its administration.

(b) The Secretary, in consultation with the Chairman of the Council of Economic Advisers, shall submit to the President, through the Assistants to the President for Domestic and Economic Policy, a report within 180 days from the date of this order that identifies approaches to modify Medicare FFS payments to more closely reflect the prices paid for services in MA and the commercial insurance market, to encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement.

SEC. 4. *Improving Access Through Network Adequacy*. Within 1 year of the date of this order, the Secretary shall propose a regulation to provide beneficiaries with improved access to providers and plans by adjusting network adequacy requirements for MA plans to account for:

(a) the competitiveness of the health market in the States in which such plans operate, including whether those States maintain certificate-of-need laws or other anti-competitive restrictions on health access; and

(b) the enhanced access to health outcomes made possible through telehealth services or other innovative technologies.

SEC. 5. *Enabling Providers to Spend More Time with Patients*. Within 1 year of the date of this order, the Secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients by:

(a) proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession;

(b) proposing a regulation that would ensure appropriate reimbursement by Medicare for time spent with patients by both primary and specialist health providers practicing in all types of health professions; and

(c) conducting a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and proposing a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician's occupation.

SEC. 6. *Encouraging Innovation for Patients*. Within 1 year of the date of this order, the Secretary shall propose regulatory and sub-regulatory changes to the Medicare program to encourage innovation for patients by:

(a) streamlining the approval, coverage, and coding process so that innovative products are brought to market faster, and so that such products, including breakthrough medical devices and advances in telehealth services and similar technologies, are appropriately reimbursed and widely available, consistent with the principles of patient safety, market-based policies, and value for patients. This process shall include:

(i) adopting regulations and guidance that minimize and eliminate, as appropriate, the time and steps between approval by the Food and Drug Administration (FDA) and coverage decisions by the Centers for Medicare and Medicaid Services (CMS);

(ii) clarifying the application of coverage standards, including the evidence standards CMS uses in applying its reasonable-and-necessary standard, the standards for deciding appeals of coverage decisions, and the prioritization and timeline for each National Coverage Determination process in light of changes made to local coverage determination processes; and

(iii) identifying challenges to the use of parallel FDA and CMS review and proposing changes to address those challenges; and

(b) modifying the Value-Based Insurance Design payment model to remove any disincentives for MA plans to cover items and services that make use of new technologies that are not covered by FFS Medicare when those items and services can save money and improve the quality of care.

SEC. 7. *Rewarding Care Through Site Neutrality*. The Secretary shall ensure that Medicare payments and policies encourage competition and a diversity of sites for patients to access care.

SEC. 8. *Empowering Patients, Caregivers, and Health Providers*. (a) Within 1 year of the date of this order, the Secretary shall propose a regulation that would provide seniors with better quality care and cost data, improving their ability to make decisions about their healthcare that work best for them and to hold providers and plans accountable.

(b) Within 1 year of the date of this order, the Secretary shall use Medicare claims data to give health providers additional information regarding practice patterns for services that may pose undue risks to patients, and to inform health providers about practice patterns that are outliers or that are outside recommended standards of care.

SEC. 9. *Eliminating Waste, Fraud, and Abuse to Protect Beneficiaries and Taxpayers*. (a) The Secretary shall propose regulatory or sub-regulatory changes to the Medicare program, to take effect by January 1, 2021, and shall propose such changes annually thereafter, to combat fraud, waste, and abuse in the Medicare program. The Secretary shall undertake all appropriate efforts to direct public and private resources toward detecting and preventing fraud, waste, and abuse, including through the use of the latest technologies such as artificial intelligence.

(b) The Secretary shall study and, within 180 days of the date of this order, recommend approaches to transition toward true market-based pricing in the FFS Medicare program. The Secretary shall submit the results of this study to the President through the Assistants to the President for Domestic and Economic Policy. Approaches studied shall include:

(i) shared savings and competitive bidding in FFS Medicare;

(ii) use of MA-negotiated rates to set FFS Medicare rates; and

(iii) novel approaches to information development and sharing that may enable markets to lower cost and improve quality for FFS Medicare beneficiaries.

SEC. 10. *Reducing Obstacles to Improved Patient Care.* Within 1 year of the date of this order, the Secretary shall propose regulatory changes to the Medicare program to reduce the burden on providers and eliminate regulations that create inefficiencies or otherwise undermine patient outcomes.

SEC. 11. *Maximizing Freedom for Medicare Patients and Providers.* (a) Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes for beneficiaries.

(b) Within 1 year of the date of this order, the Secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.

SEC. 12. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

(Aug. 14, 1935, ch. 531, title XVIII, § 1801, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Statutory Notes and Related Subsidiaries

SHORT TITLE

For short title of title I of Pub. L. 89–97, which enacted this subchapter as the ''Health Insurance for the Aged Act'', see section 100 of Pub. L. 89–97, set out as a Short Title of 1965 Amendment note under section 1305 of this title.

PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

Pub. L. 111–148, title III, § 3601, Mar. 23, 2010, 124 Stat. 538, provided that:

''(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act [see Short Title note set out under section 18001 of this title] shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.''

§ 1395a. Free choice by patient guaranteed

(a) Basic freedom of choice

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

(b) Use of private contracts by medicare beneficiaries

(1) In general

Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this subchapter, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this subchapter directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.

(2) Beneficiary protections

(A) In general

Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

(ii) the contract contains the items described in subparagraph (B); and

(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

(B) Items required to be included in contract

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this subchapter for such items or services even if such items or services are otherwise covered by this subchapter;

(ii) agrees to be responsible, whether through insurance or otherwise, for pay-

ment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;

(iii) acknowledges that no limits under this subchapter (including the limits under section 1395w–4(g) of this title) apply to amounts that may be charged for such items or services;

(iv) acknowledges that Medigap plans under section 1395ss of this title do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this subchapter; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this subchapter.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1320a–7 of this title.

(3) Physician or practitioner requirements

(A) In general

Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) Affidavit

An affidavit is described in this subparagraph if—

(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this subchapter for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the applicable 2-year period (as defined in subparagraph (D)); and

(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(C) Enforcement

If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this subchapter for any item or service provided during the applicable 2-year period (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

(ii) no payment shall be made under this subchapter for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

(D) Applicable 2-year periods for effectiveness of affidavits

In this subsection, the term ''applicable 2-year period'' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.

(4) Limitation on actual charge and claim submission requirement not applicable

Section 1395w–4(g) of this title shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).

(5) Posting of information on opt-out physicians and practitioners

(A) In general

Beginning not later than February 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

(B) Information to be included

The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

(i) Their number.

(ii) Their physician or professional specialty or other designation.

(iii) Their geographic distribution.

(iv) The timing of their becoming opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled in the program under this subchapter and with respect to applicable 2-year periods.

(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.

(6) Definitions

In this subsection:

(A) Medicare beneficiary

The term ''medicare beneficiary'' means an individual who is entitled to benefits under part A or enrolled under part B.

(B) Physician

The term ''physician'' has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1395x(r) of this title.

(C) Practitioner

The term ''practitioner'' has the meaning given such term by section 1395u(b)(18)(C) of this title.

(D) Opt-out physician or practitioner

The term ''opt-out physician or practitioner'' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).

(Aug. 14, 1935, ch. 531, title XVIII, § 1802, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 105–33, title IV, § 4507(a)(1), (2)(A), Aug. 5, 1997, 111 Stat. 439, 441; Pub. L. 108–173, title VI, § 603, Dec. 8, 2003, 117 Stat. 2301; Pub. L. 114–10, title I, § 106(a)(1)(A), (2), Apr. 16, 2015, 129 Stat. 137, 138.)

Editorial Notes

AMENDMENTS

2015—Subsec. (b)(3)(B)(ii). Pub. L. 114–10, § 106(a)(1)(A)(i), substituted ''during the applicable 2-year period (as defined in subparagraph (D))'' for ''during the 2-year period beginning on the date the affidavit is signed''.

Subsec. (b)(3)(C). Pub. L. 114–10, § 106(a)(1)(A)(ii), substituted ''during the applicable 2-year period'' for ''during the 2-year period described in subparagraph (B)(ii)'' in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 114–10, § 106(a)(1)(A)(iii), added subpar. (D).

Subsec. (b)(5). Pub. L. 114–10, § 106(a)(2)(C), added par. (5). Former par. (5) redesignated (6).

Subsec. (b)(5)(D). Pub. L. 114–10, § 106(a)(2)(A), added subpar. (D).

Subsec. (b)(6). Pub. L. 114–10, § 106(a)(2)(B), redesignated par. (5) as (6).

2003—Subsec. (b)(5)(B). Pub. L. 108–173 substituted ''paragraphs (1), (2), (3), and (4) of section 1395x(r)'' for ''section 1395x(r)(1)''.

1997—Pub. L. 105–33 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title I, § 106(a)(1)(B), Apr. 16, 2015, 129 Stat. 138, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act [Apr. 16, 2015].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4507(c), Aug. 5, 1997, 111 Stat. 442, provided that: ''The amendment made by subsection (a) [amending this section and section 1395y of this title] shall apply with respect to contracts entered into on and after January 1, 1998.''

UPDATING THE WELCOME TO MEDICARE PACKAGE

Pub. L. 114–255, div. C, title XVII, § 17003, Dec. 13, 2016, 130 Stat. 1331, provided that:

''(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w–21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w–101 et seq.)). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

''(b) REQUEST FOR INFORMATION.—Not later than 6 months after the date of the enactment of this Act [Dec. 13, 2016], the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.''

REPORT TO CONGRESS ON EFFECT OF PRIVATE CONTRACTS

Pub. L. 105–33, title IV, § 4507(b), Aug. 5, 1997, 111 Stat. 441, required a report to be submitted to Congress, no later than Oct. 1, 2001, on the effect on the program under title IV of Pub. L. 105–33 of certain private contracts.

§ 1395b. Option to individuals to obtain other health insurance protection

Nothing contained in this subchapter shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

(Aug. 14, 1935, ch. 531, title XVIII, § 1803, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Statutory Notes and Related Subsidiaries

IMPACT OF INCREASED INVESTMENTS IN HEALTH RESEARCH ON FUTURE MEDICARE COSTS

Pub. L. 105–78, title II, Nov. 13, 1997, 111 Stat. 1484, provided in part: ''That in carrying out its legislative mandate, the National Bipartisan Commission on the Future of Medicare shall examine the impact of increased investments in health research on future Medicare costs, and the potential for coordinating Medicare with cost-effective long-term care services''.

NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Pub. L. 105–33, title IV, § 4021, Aug. 5, 1997, 111 Stat. 347, established National Bipartisan Commission on the Future of Medicare which was directed to review and analyze long-term financial condition of medicare program, identify problems that threaten financial integrity of Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund, analyze potential solutions that will ensure both financial integrity of medicare program and provision of appropriate benefits under such program, and make recommendations for, among other things, restoring solvency of Federal Hospital Insurance Trust Fund and financial integrity of Federal Supplementary Medical Insurance Trust Fund, establishing appropriate financial structure of medicare program as a whole, and establishing appropriate balance of benefits covered and beneficiary contributions to medicare program, further provided for membership of Commission, meetings, personnel and staff matters, powers of Commission, appropriations, submission of final report to Congress not later than Mar. 1, 1999, and termination of Commission 30 days after submission of final report.

EXCLUSION FROM WAGES AND COMPENSATION OF REFUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY EMPLOYERS

Pub. L. 101–239, title X, § 10202, Dec. 19, 1989, 103 Stat. 2473, provided that:

''(a) OLD-AGE, SURVIVORS, AND DISABILITY, AND HOSPITAL INSURANCE PROGRAMS.—For purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.] and chapter 21 of the Internal Revenue Code of 1986 [26 U.S.C. 3101 et seq.], the term 'wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 [section 421 of Pub. L. 100–360, formerly set out as a note below].

''(b) RAILROAD RETIREMENT PROGRAM.—For purposes of chapter 22 of the Internal Revenue Code of 1986 [26 U.S.C. 3201 et seq.], the term 'compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

''(c) FEDERAL UNEMPLOYMENT PROGRAMS.—

''(1) FEDERAL UNEMPLOYMENT TAX.—For purposes of chapter 23 of the Internal Revenue Code of 1986 [26 U.S.C. 3301 et seq.], the term 'wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

''(2) RAILROAD UNEMPLOYMENT CONTRIBUTIONS.—For purposes of the Railroad Unemployment Insurance Act [45 U.S.C. 351 et seq.], the term 'compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

''(3) RAILROAD UNEMPLOYMENT REPAYMENT TAX.—For purposes of chapter 23A of the Internal Revenue Code of 1986 [26 U.S.C. 3321 et seq.], the term 'rail wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

''(d) REPORTING REQUIREMENTS.—Any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 shall be reported to the Secretary of the Treasury or his delegate and to the person to whom such refund is made in such manner as the Secretary of the Treasury or his delegate shall prescribe.

''(e) EFFECTIVE DATE.—This section shall apply with respect to refunds provided on or after January 1, 1989.''

UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Pub. L. 100–360, title IV, subtitle A, §§ 401–408, July 1, 1988, 102 Stat. 765–768, as amended by Pub. L. 100–647, title VIII, § 8414, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–239, title VI, § 6220, Dec. 19, 1989, 103 Stat. 2254, established the United States Bipartisan Commission on Comprehensive Health Care, also known as the ''Claude Pepper Commission'' or the ''Pepper Commission'', and directed Commission to examine shortcomings in health care delivery and financing mechanisms that limit or prevent access of all individuals in United States to comprehensive health care, and make specific recommendations respecting Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for elderly and disabled, as well as comprehensive health care services for all individuals in the United States, and further provided for membership of Commission, staff and consultants, powers, authorization of appropriations, submission of findings and recommendations to Congress not later than Nov. 9, 1989, and for termination of Commission 30 days after submissions to Congress.

MAINTENANCE OF EFFORT REGARDING DUPLICATIVE BENEFITS

Pub. L. 100–360, title IV, § 421, July 1, 1988, 102 Stat. 808, as amended by Pub. L. 100–485, title VI, § 608(a), Oct. 13, 1988, 102 Stat. 2411, which required employers who had been providing health care benefits to employees that were duplicative part A and part B benefits to provide the employees with additional benefits equal to the total actuarial value of such duplicative benefits, was repealed by Pub. L. 101–234, title III, § 301(a), Dec. 13, 1989, 103 Stat. 1985. [Repeal not applicable to duplicative part A benefits for periods before Jan. 1, 1990, see section 301(e)(1) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 1395u of this title.]

TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

Pub. L. 99–272, title IX, § 9601, Apr. 7, 1986, 100 Stat. 221, as amended by Pub. L. 105–362, title VI, § 601(b)(3), Nov. 10, 1998, 112 Stat. 3286, directed Secretary of Health and Human Services, in consultation with National Association of Insurance Commissioners, to establish Task Force on Long-Term Health Care Policies to develop recommendations for long-term health care policies designed to limit marketing and agent abuse for those policies, to assure dissemination of such information to consumers as is necessary to permit informed choice in purchasing policies and to reduce purchase of unnecessary or duplicative coverage, to assure that benefits provided under policies are reasonable in relationship to premiums charged, and to promote development and availability of long-term health care policies which meet these recommendations, and further provided for composition of Task Force, definition of long-term health care policy, assurance of States' jurisdiction, submission of recommendations to Secretary and Congress not later than 18 months after Apr. 7, 1986, and termination of Task Force 90 days after submission of recommendations.

§ 1395b–1. Incentives for economy while maintaining or improving quality in provision of health services

(a) Grants and contracts to develop and engage in experiments and demonstration projects

(1) The Secretary of Health and Human Services is authorized, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

(B) to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing—

(i) comprehensive health care services,

(ii) mental health care services (as defined by section 2691(c)[1] of this title),

(iii) ambulatory health care services (including surgical services provided on an outpatient basis), or

(iv) institutional services which may substitute, at lower cost, for hospital care;

(C) to determine whether the rates of payment or reimbursement for health care serv-

[1] See References in Text note below.

ices, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by this chapter, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;

(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge for the teaching activities and patient care which residents, interns, and supervising physicians render in connection with a graduate medical education program in a patient facility would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care;

(E) to determine whether coverage of intermediate care facility services and homemaker services would provide suitable alternatives to posthospital benefits presently provided under this subchapter; such experiment and demonstration projects may include:

(i) counting each day of care in an intermediate care facility as one day of care in a skilled nursing facility, if such care was for a condition for which the individual was hospitalized,

(ii) covering the services of homemakers for a maximum of 21 days, if institutional services are not medically appropriate,

(iii) determining whether such coverage would reduce long-range costs by reducing the lengths of stay in hospitals and skilled nursing facilities, and

(iv) establishing alternative eligibility requirements and determining the probable cost of applying each alternative, if the project suggests that such extension of coverage would be desirable;

(F) to determine whether, and if so which type of, fixed price or performance incentive contract would have the effect of inducing to the greatest degree effective, efficient, and economical performance of agencies and organizations making payment under agreements or contracts with the Secretary for health care and services under health programs established by this chapter;

(G) to determine under what circumstances payment for services would be appropriate and the most appropriate, equitable, and noninflationary methods and amounts of reimbursement under health care programs established by this chapter for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and—

(i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed, and

(ii) for which such physician assumes full legal and ethical responsibility as to the necessity, propriety, and quality thereof;

(H) to establish an experimental program to provide day-care services, which consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under part B of this subchapter and subchapter XIX of this chapter, in day-care centers which meet such standards as the Secretary shall by regulation establish;

(I) to determine whether the services of clinical psychologists may be made more generally available to persons eligible for services under this subchapter and subchapter XIX of this chapter in a manner consistent with quality of care and equitable and efficient administration;

(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by this chapter; and

(K) to determine whether the use of competitive bidding in the awarding of contracts, or the use of other methods of reimbursement, under part B of subchapter XI would be efficient and effective methods of furthering the purposes of that part.

For purposes of this subsection, ''health programs established by this chapter'' means the program established by this subchapter and a program established by a plan of a State approved under subchapter XIX of this chapter.

(2) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under paragraph (1) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1395t of this title) and from funds appropriated under subchapter XIX of this chapter. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such subchapter XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(b) Waiver of certain payment or reimbursement requirements; advice and recommendations of specialists preceding experiments and demonstration projects

In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of this subchapter and subchapter XIX of this chapter insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment; and costs incurred in such experiment or demonstration project in excess of the costs which would otherwise be reimbursed or paid under such sub-

chapters may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be engaged in or developed under subsection (a) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process.

(Pub. L. 90–248, title IV, § 402(a), (b), Jan. 2, 1968, 81 Stat. 930, 931; Pub. L. 92–603, title II, §§ 222(b), 278(b)(2), Oct. 30, 1972, 86 Stat. 1391, 1453; Pub. L. 95–142, § 17(d), Oct. 25, 1977, 91 Stat. 1202; Pub. L. 96–88, title V, § 509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, § 2193(d), Aug. 13, 1981, 95 Stat. 828; Pub. L. 97–248, title I, § 147, Sept. 3, 1982, 96 Stat. 394; Pub. L. 98–369, div. B, title III, § 2331(b), July 18, 1984, 98 Stat. 1088.)

Editorial Notes

References in Text

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(A), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note below.

Section 2691(c) of this title, referred to in subsec. (a)(1)(B)(ii), was repealed by Pub. L. 94–103, title III, § 302(c), Oct. 4, 1975, 89 Stat. 507.

Codification

Section is comprised of subsecs. (a) and (b) of section 402 of Pub. L. 90–248. Subsec. (c) of such section 402 amended section 1395*ll*(b) of this title.

Section was enacted as a part of the Social Security Amendments of 1967, and not as a part of the Social Security Act which comprises this chapter.

Amendments

1984—Subsec. (a)(1). Pub. L. 98–369 substituted ''grants to public or private agencies'' for ''grants to public or nonprofit private agencies'' in provisions preceding subpar. (A).

1982—Subsec. (a)(1)(K). Pub. L. 97–248 added subpar. (K).

1981—Subsec. (a)(1). Pub. L. 97–35, § 2193(d)(1), substituted ''this subchapter and a program established by a plan of a State approved under subchapter XIX of this chapter'' for ''this subchapter, a program established by a plan of a State approved under subchapter XIX of this chapter, and a program established by a plan of a State approved under subchapter V of this chapter''.

Subsec. (a)(2). Pub. L. 97–35, § 2193(d)(2), substituted reference to subchapter XIX of this chapter for reference to subchapters V and XIX of this chapter in two places.

Subsec. (b). Pub. L. 97–35, § 2193(d)(3), substituted reference to subchapter XIX of this chapter for reference to subchapters V and XIX of this chapter.

1977—Subsec. (a)(1)(J). Pub. L. 95–142 added subpar. (J).

1972—Subsec. (a). Pub. L. 92–603, §§ 222(b)(1), 278(b)(2), substituted provisions spelling out in detail the purposes for which experiments and demonstration projects may be carried out for a general statement setting out the increase in efficiency and economy of health services as the purpose of experiments selected by the Secretary, inserted references to demonstration projects, and inserted references to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Subsec. (b). Pub. L. 92–603, § 222(b)(2), inserted references to demonstration projects and inserted '', or to reimbursement or payment only for such services or items as may be specified in the experiment''.

Statutory Notes and Related Subsidiaries

Change of Name

''Secretary of Health and Human Services'' substituted in text for ''Secretary of Health, Education, and Welfare'' pursuant to section 509(b) Pub. L. 96–88, which is classified to section 3508(b) of Title 20, Education.

Effective Date of 1984 Amendment

Amendment by Pub. L. 98–369 effective July 18, 1984, see section 2331(c) of Pub. L. 98–369, set out as a note under section 1310 of this title.

Effective Date of 1982 Amendment

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

Effective Date of 1981 Amendment, Savings, and Transitional Provisions

For effective date, savings, and transitional provisions relating to amendment by Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Community-Based Care Transitions Program

Pub. L. 111–148, title III, § 3026, Mar. 23, 2010, 124 Stat. 413, provided that:

''(a) In General.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

''(b) Definitions.—In this section:

''(1) Eligible entity.—The term 'eligible entity' means the following:

''(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

''(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

''(2) High-risk Medicare beneficiary.—The term 'high-risk Medicare beneficiary' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

''(A) Cognitive impairment.

''(B) Depression.

''(C) A history of multiple readmissions.

''(D) Any other chronic disease or risk factor as determined by the Secretary.

''(3) Medicare beneficiary.—The term 'Medicare beneficiary' means an individual who is entitled to benefits under part A [42 U.S.C. 1395c et seq.] of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B [42 U.S.C. 1395j et seq.] of such title, but not enrolled under part C [42 U.S.C. 1395w–21 et seq.] of such title.

''(4) PROGRAM.—The term 'program' means the program conducted under this section.

''(5) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act [42 U.S.C. 1395ww(q)(5)(E)], as added by section 3025.

''(6) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(c) REQUIREMENTS.—

''(1) DURATION.—

''(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

''(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title [title III of Pub. L. 111–148, see Tables for classification], certifies) that such expansion would reduce spending under this title without reducing quality.

''(2) APPLICATION; PARTICIPATION.—

''(A) IN GENERAL.—

''(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

''(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

''(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

''(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

''(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

''(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

''(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

''(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

''(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

''(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

''(B) provide services to medically underserved populations, small communities, and rural areas.

''(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the program.

''(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.''

PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS

Pub. L. 111–148, title X, §10326, Mar. 23, 2010, 124 Stat. 961, provided that:

''(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to test the implementation of a value-based purchasing program for payments under such title for the provider.

''(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

''(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

''(2) Long-term care hospitals (as described in clause (iv) of such section).

''(3) Rehabilitation hospitals (as described in clause (ii) of such section).

''(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

''(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

''(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary solely for purposes of carrying out the pilot programs under this section.

''(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

''(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected to—

''(A) reduce spending under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] without reducing the quality of care; or

''(B) improve the quality of care and reduce spending;

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII [XVIII] for Medicare beneficiaries.''

MEDICARE MEDICAL HOME DEMONSTRATION PROJECT

Pub. L. 109–432, div. B, title II, § 204, Dec. 20, 2006, 120 Stat. 2987, as amended by Pub. L. 110–275, title I, § 133(a), July 15, 2008, 122 Stat. 2531, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] a medical home demonstration project (in this section referred to as the 'project') to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which—

''(1) care management fees are paid to persons performing services as personal physicians; and

''(2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

For purposes of this subsection, the term 'high-need population' means individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.

''(b) DETAILS.—

''(1) DURATION; SCOPE.—Subject to paragraph (3), the project shall operate during a period of three years and shall include urban, rural, and underserved areas in a total of no more than 8 States.

''(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—The project shall be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

''(3) EXPANSION.—The Secretary may expand the duration and the scope of the project under paragraph (1), to an extent determined appropriate by the Secretary, if the Secretary determines that such expansion will result in any of the following conditions being met:

''(A) The expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program (not taking into account amounts available under subsection (g)).

''(B) The expansion of the project is expected to reduce spending under the Medicare program (not taking into account amounts available under subsection (g)) without reducing the quality of patient care.

''(c) PERSONAL PHYSICIAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'personal physician' means a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))[)] who—

''(A) meets the requirements described in paragraph (2); and

''(B) performs the services described in paragraph (3).

Nothing in this paragraph shall be construed as preventing such a physician from being a specialist or subspecialist for an individual requiring ongoing care for a specific chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for an individual with a prolonged illness.

''(2) REQUIREMENTS.—The requirements described in this paragraph for a personal physician are as follows:

''(A) The physician is a board certified physician who provides first contact and continuous care for individuals under the physician's care.

''(B) The physician has the staff and resources to manage the comprehensive and coordinated health care of each such individual.

''(3) SERVICES PERFORMED.—A personal physician shall perform or provide for the performance of at least the following services:

''(A) Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies).

''(B) Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

''(C) Uses health information technology, that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

''(D) Encourages patients to engage in the management of their own health through education and support systems.

''(d) MEDICAL HOME DEFINED.—For purposes of this section, the term 'medical home' means a physician practice that—

''(1) is in charge of targeting beneficiaries for participation in the project; and

''(2) is responsible for—

''(A) providing safe and secure technology to promote patient access to personal health information;

''(B) developing a health assessment tool for the individuals targeted; and

''(C) providing training programs for personnel involved in the coordination of care.

''(e) PAYMENT MECHANISMS.—

''(1) PERSONAL PHYSICIAN CARE MANAGEMENT FEE.—Under the project, the Secretary shall provide for payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) of a care management fee to personal physicians providing care management under the project. Under such section and using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code.

''(2) MEDICAL HOME SHARING IN SAVINGS.—The Secretary shall provide for payment under the project of a medical home based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act (42 U.S.C. 1395cc–1). Under such methodology, 80 percent of the reductions in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] resulting from participation of individuals that are attributable to the medical home (as reduced by the total care managements fees paid to the medical home under the project) shall be paid to the medical home. The amount of such reductions in expenditures shall be determined by using assumptions with respect to reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions.

''(3) SOURCE.—Payments paid under the project shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

''(f) EVALUATIONS AND REPORTS.—

''(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

''(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the project and shall submit to Congress, not later than one year after completion of the project, a report on the project and on the evaluation of the project.

''(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

''(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.''

POST-ACUTE CARE PAYMENT REFORM DEMONSTRATION PROGRAM

Pub. L. 109–171, title V, § 5008, Feb. 8, 2006, 120 Stat. 36, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—By not later than January 1, 2008, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration program for purposes of understanding costs and outcomes across different post-acute care sites. Under such program, with respect to diagnoses specified by the Secretary, an individual who receives treatment from a provider for such a diagnosis shall receive a single comprehensive assessment on the date of discharge from a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) of the needs of the patient and the clinical characteristics of the diagnosis to determine the appropriate placement of such patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider. Participants in the program shall provide information on the fixed and variable costs for each individual. An additional comprehensive assessment shall be provided at the end of the episode of care.

''(2) NUMBER OF SITES.—The Secretary shall conduct the demonstration program under this section with sufficient numbers to determine statistically reliable results.

''(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

''(b) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

''(c) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, that includes the results of the program and recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

''(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i), $6,000,000 for the costs of carrying out the demonstration program under this section.''

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Pub. L. 108–173, title VI, § 649, Dec. 8, 2003, 117 Stat. 2329, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

''(A) promoting continuity of care;

''(B) helping stabilize medical conditions;

''(C) preventing or minimizing acute exacerbations of chronic conditions; and

''(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

''(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which—

''(A) two shall be in an urban area;

''(B) one shall be in a rural area; and

''(C) one shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

''(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

''(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

''(b) PARTICIPATION.—

''(1) IN GENERAL.—A physician who provides care for a minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase-in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)—

''(A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and

''(B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

''(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

''(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability—

''(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing care management requirements;

''(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;

''(C) to establish and maintain health care information system for such beneficiaries;

''(D) to promote continuity of care across providers and settings;

''(E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;

''(F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;

''(G) when appropriate, to refer such beneficiaries to community service organizations; and

''(H) to meet such other complex care management requirements as the Secretary may specify.

The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

''(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

''(d) ADMINISTRATION.—

''(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.

''(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be re-

sponsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

''(e) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

''(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

''(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

''(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

''(h) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means any individual who—

''(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] and is not enrolled in a plan under part C of such title [42 U.S.C. 1395w–21 et seq.]; and

''(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

''(2) HEALTH INFORMATION TECHNOLOGY.—The term 'health information technology' means email communication, clinical alerts and reminders, and other information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.''

DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES

Pub. L. 106–554, §1(a)(6) [title I, §121], Dec. 21, 2000, 114 Stat. 2763, 2763A–474, provided that the Secretary of Health and Human Services was to conduct a demonstration project under this section to demonstrate the impact on costs and health outcomes of applying disease management to medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease, that the project was to last for not longer than 3 years, and that the Secretary was to submit a final report to Congress not later than 6 months after the project's completion.

CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES

Pub. L. 106–554, §1(a)(6) [title I, §122], Dec. 21, 2000, 114 Stat. 2763, 2763A–476, provided that:

''(a) DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct demonstration projects (in this section referred to as 'demonstration projects') for the purpose of developing models and evaluating methods that—

''(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

''(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of medicare-covered services and referral patterns among those target individuals with cancer;

''(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears and prostate cancer screenings, among target individuals; and

''(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

''(2) TARGET INDIVIDUAL DEFINED.—In this section, the term 'target individual' means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service Act [42 U.S.C. 300u–6], who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

''(b) PROGRAM DESIGN.—

''(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

''(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least nine demonstration projects, including the following:

''(A) Two projects for each of the four following major racial and ethnic minority groups:

''(i) American Indians, including Alaska Natives, Eskimos, and Aleuts.

''(ii) Asian Americans and Pacific Islanders.

''(iii) Blacks.

''(iv) Hispanics.

The two projects must target different ethnic subpopulations.

''(B) One project within the Pacific Islands.

''(C) At least one project each in a rural area and inner-city area.

''(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

''(A) reduce expenditures under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; or

''(B) do not increase expenditures under the medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 2 years after the date the Secretary implements the initial demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

''(2) CONTENTS OF REPORT.—Each report under paragraph (1) shall include the following:

''(A) A description of the demonstration projects.

''(B) An evaluation of—

''(i) the cost-effectiveness of the demonstration projects;

''(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

''(iii) beneficiary and health care provider satisfaction under the demonstration projects.

''(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

''(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the

Social Security Act [42 U.S.C. 1395 et seq.] to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(e) FUNDING.—

''(1) DEMONSTRATION PROJECTS.—

''(A) STATE PROJECTS.—Except as provided in subparagraph (B), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary [Medical] Insurance Trust Fund under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects.

''(B) TERRITORY PROJECTS.—In the case of a demonstration project described in subsection (b)(2)(B), amounts shall be available only as provided in any Federal law making appropriations for the territories.

''(2) LIMITATION.—In conducting demonstration projects, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the sum of the amount which the Secretary would have paid under the program for the prevention and treatment of cancer if the demonstration projects were not implemented, plus $25,000,000.''

LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION

Pub. L. 106–554, § 1(a)(6) [title I, § 128], Dec. 21, 2000, 114 Stat. 2763, 2763A–480, as amended by Pub. L. 108–173, title VII, § 736(b)(13), Dec. 8, 2003, 117 Stat. 2356, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, and as subsequently modified, (in this section referred to as the 'project') in accordance with the following requirements:

''(1) The project shall include no fewer than 1,800 medicare beneficiaries who complete under the project the entire course of treatment under the Lifestyle Modification Program.

''(2) The project shall be conducted over a course of 4 years.

''(b) STUDY ON COST-EFFECTIVENESS.—

''(1) STUDY.—The Secretary shall conduct a study on the cost-effectiveness of the Lifestyle Modification Program as conducted under the project. In determining whether such Program is cost-effective, the Secretary shall determine (using a control group under a matched paired experimental design) whether expenditures incurred for medicare beneficiaries enrolled under the project exceed expenditures for the control group of medicare beneficiaries with similar health conditions who are not enrolled under the project.

''(2) REPORTS.—

''(A) INITIAL REPORT.—Not later than 1 year after the date on which 900 medicare beneficiaries have completed the entire course of treatment under the Lifestyle Modification Program under the project, the Secretary shall submit to Congress an initial report on the study conducted under paragraph (1).

''(B) FINAL REPORT.—Not later than 1 year after the date on which 1,800 medicare beneficiaries have completed the entire course of treatment under such Program under the project, the Secretary shall submit to Congress a final report on the study conducted under paragraph (1).''

MEDICARE COORDINATED CARE DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, § 4016, Aug. 5, 1997, 111 Stat. 343, as amended by Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 535], Nov. 29, 1999, 113 Stat. 1536, 1501A–390, provided that:

''(a) DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

''(A) improve the quality of items and services provided to target individuals; and

''(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

''(2) TARGET INDIVIDUAL DEFINED.—In this section, the term 'target individual' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

''(b) PROGRAM DESIGN.—

''(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

''(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act [Aug. 5, 1997], the Secretary shall implement at least 9 demonstration projects, including—

''(A) 5 projects in urban areas;

''(B) 3 projects in rural areas; and

''(C) 1 project within the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center.

''(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

''(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

''(i) reduce expenditures under the medicare program; or

''(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

''(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

''(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

''(A) A description of the demonstration projects conducted under this section.

''(B) An evaluation of—

''(i) the cost-effectiveness of the demonstration projects;

''(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

''(iii) beneficiary and health care provider satisfaction under the demonstration project.

''(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

''(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such ex-

tent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(e) FUNDING.—

''(1) DEMONSTRATION PROJECTS.—

''(A) IN GENERAL.—

''(i) STATE PROJECTS.—Except as provided in clause (ii), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary [Medical] Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

''(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund [Medical] under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.

''(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

''(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).''

INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §4207, Aug. 5, 1997, 111 Stat. 379, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §413], Nov. 29, 1999, 113 Stat. 1536, 1501A–377; Pub. L. 108–173, title IV, §417, Dec. 8, 2003, 117 Stat. 2282, provided that:

''(a) PURPOSE AND AUTHORIZATION.—

''(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section [Aug. 5, 1997], the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2). The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 [Nov. 29, 1999]. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.

''(2) DESCRIPTION OF PROJECT.—

''(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project.

''(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term 'medically underserved' has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

''(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act [this subchapter] as may be necessary to provide for payment for services under the project in accordance with subsection (d).

''(4) DURATION OF PROJECT.—The project shall be conducted over a 8-year period.

''(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

''(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

''(2) Developing a curriculum to train health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

''(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

''(4) Application of medical informatics to residents with limited English language skills.

''(5) Developing standards in the application of telemedicine and medical informatics.

''(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

''(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term 'eligible health care provider telemedicine network' means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

''(1) The consortium is located in an area with a high concentration of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

''(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project.

''(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

''(d) COVERAGE AS MEDICARE PART B SERVICES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].

''(2) PAYMENTS.—

''(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made for the costs that are related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

''(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

''(i) The acquisition of telemedicine equipment for use in patients' homes or at sites providing

health care to patients located in medically underserved areas.

''(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

''(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

''(iv) Payments to practitioners and providers under the medicare programs.

''(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

''(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals for activities related to the project).

''(ii) The establishment or operation of a telecommunications common carrier network.

''(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

''(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $60,000,000 for the period of the project (described in subsection (a)(4)).

''(4) COST-SHARING.—The project may not impose cost-sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to medicare beneficiaries and providers related to participation in the project.

''(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee [on] Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

''(f) DEFINITIONS.—For purposes of this section:

''(1) INTERVENTIONAL INFORMATICS.—The term 'interventional informatics' means using information technology and virtual reality technology to intervene in patient care.

''(2) MEDICAL INFORMATICS.—The term 'medical informatics' means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

''(3) PROJECT.—The term 'project' means the demonstration project under this section.''

CLARIFICATION OF SECRETARIAL WAIVER AUTHORITY FOR RURAL HOSPITAL DEMONSTRATIONS

Pub. L. 101–508, title IV, § 4008(i)(1), Nov. 5, 1990, 104 Stat. 1388–50, as amended by Pub. L. 103–66, title XIII, § 13507, Aug. 10, 1993, 107 Stat. 579, provided that: ''The Secretary of Health and Human Services is authorized to waive such provisions of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as are necessary to conduct any demonstration project for limited-service rural hospitals with respect to which the Secretary has entered into an agreement before the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 [Dec. 19, 1989]. The Secretary shall continue any such demonstration project until at least July 1, 1997.''

VOLUNTEER SENIOR AIDES DEMONSTRATION PROJECTS FOR BASIC MEDICAL ASSISTANCE AND SUPPORT TO FAMILIES WITH DISABLED OR ILL CHILDREN

Pub. L. 101–239, title X, § 10404, Dec. 19, 1989, 103 Stat. 2488, provided that:

''(a) NUMBER OF PROJECTS.—In order to determine whether, and if so, the extent to which, the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children contributes to reducing the costs of care for such children, not more than 10 communities may conduct demonstration projects under this section.

''(b) DUTIES OF THE SECRETARY.—

''(1) CONSIDERATION OF APPLICATIONS.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall consider all applications received from communities desiring to conduct demonstration projects under this section.

''(2) APPROVAL OF CERTAIN APPLICATIONS.—The Secretary shall approve not more than 10 applications to conduct projects which appear likely to contribute significantly to the achievement of the purpose of this section.

''(3) GRANTS.—The Secretary shall make grants to each community the application of which to conduct a demonstration project under this section is approved by the Secretary to assist the community in carrying out the project.

''(c) REQUIREMENTS.—Each community receiving a grant with respect to a demonstration project under this section shall conduct the project in accordance with such requirements as the Secretary may prescribe.

''(d) LIMITATION ON AUTHORIZATION OF APPROPRIATIONS.—For grants under this section, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed—

''(1) $1,000,000 for each of the fiscal years 1990 and 1991; and

''(2) $2,000,000 for each of the fiscal years 1992, 1993, and 1994.

''(e) EFFECTIVE DATE.—This section shall take effect on October 1, 1989.''

TREATMENT OF CERTAIN NURSING EDUCATION PROGRAMS

Pub. L. 100–647, title VIII, § 8411, Nov. 10, 1988, 102 Stat. 3800, as amended by Pub. L. 101–239, title VI, § 6205(a)(1)(B), Dec. 19, 1989, 103 Stat. 2243, provided that:

''(a) DEMONSTRATION OF JOINT NURSING GRADUATE EDUCATION PROGRAMS.—

''(1) The Secretary of Health and Human Services shall provide for demonstration programs under this subsection in each of 5 hospitals for cost reporting periods beginning on or after July 1, 1989, and before July 1, 1994.

''(2) Under each demonstration project, subject to paragraph (4), the reasonable costs incurred by a hospital pursuant to a written agreement with an educational institution for the activities described in paragraph (3) conducted as part of an approved educational program that—

''(A) involves a substantial clinical component (as determined by the Secretary), and

''(B) leads to a master's or doctoral degree in nursing,

shall be allowable as reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated approved educational program (other than an approved graduate medical education program).

''(3) The activities described in this paragraph are the activities for which the reasonable costs of conducting such activities are allowable under title XVIII of the Social Security Act if conducted under a hospital-operated approved educational program (other than an approved graduate medical education program), but only to the extent such activities are directly related to the operation of the educational program conducted pursuant to the written agreement between the hospital and the educational institution.

''(4) The amount paid under a demonstration program under this subsection to a hospital for a cost reporting period may not exceed $200,000.

''(5) The Secretary shall report to Congress, by not later than January 1, 1995, on the demonstration programs conducted under this subsection and on the supply and characteristics of nurses trained under such programs.

''(b) JOINT UNDERGRADUATE EDUCATION PROGRAM.—In the case of a hospital which (1) was paid under a waiver under section 402 of the Social Security Amendments of 1967 [section 402 of Pub. L. 90–248, enacting this section and amending section 1395*ll* of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92–603, amending this section and section 1395*ll* of this title and enacting provisions set out below], which waiver expired on September 30, 1985, and (2) during its cost reporting period beginning in fiscal year 1985 and for each subsequent cost reporting period, has been and is associated with, and has incurred and incurs substantial costs with respect to, a nursing college with which it has shared and shares common directors, educational activities of the nursing college shall be considered to be educational activities operated directly by such hospital for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and shall be allowable as reasonable costs under such title and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated approved educational program (other than an approved graduate medical education program), for hospital cost reporting periods beginning in fiscal years 1986 though 1991.''

RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES

Pub. L. 100–360, title II, §207, July 1, 1988, 102 Stat. 732, which provided for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

For requirement that Secretary of Health and Human Services modify contracts with health maintenance organizations under subsec. (a) of this section and section 222(a) of Pub. L. 92–603, set out below, so as to apply to such organizations and contracts the requirements imposed by the amendments made by Pub. L. 100–360, see section 222 of Pub. L. 100–360, set out as a note under section 1395mm of this title.

CASE MANAGEMENT DEMONSTRATION PROJECTS

Pub. L. 101–508, title IV, §4207(f), formerly §4027(f), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that:

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall resume the 3 case management demonstration projects described in paragraph (2) and approved under section 425 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360, formerly set out below] (in this subsection referred to as 'MCCA').

''(2) PROJECT DESCRIPTIONS.—The demonstration projects referred to in paragraph (1) are—

''(A) the project proposed to be conducted by Providence Hospital for case management of the elderly at risk for acute hospitalization as described in Project No. 18–P–99379/5–01;

''(B) the project proposed to be conducted by the Iowa Foundation for Medical Care to study patients with chronic congestive conditions to reduce repeated hospitalizations of such patients as described in Project No. P–99399/4–01; and

''(C) the project proposed to be conducted by Key Care Health Resources, Inc., to examine the effects of case management on 2,500 high cost medicare beneficiaries as described in Project No. 18–P–99396/5.

''(3) TERMS AND CONDITIONS.—Except as provided in paragraph (4), the demonstration projects resumed pursuant to paragraph (1) shall be subject to the same terms and conditions established under section 425 of MCCA. In determining the 2-year duration period of a project resumed pursuant to paragraph (1), the Secretary may not take into account any period of time for which the project was in effect under section 425 of MCCA.

''(4) AUTHORIZATION OF APPROPRIATIONS.—Notwithstanding section 425(g) of MCCA, there are authorized to be appropriated for administrative costs in carrying out the demonstration projects resumed pursuant to paragraph (1) $2,000,000 in each of fiscal years 1991 and 1992.''

Pub. L. 100–360, title IV, §425, July 1, 1988, 102 Stat. 813, which directed Secretary of Health and Human Services to establish 4 demonstration projects under which an appropriate entity agreed to provide case management services, was repealed by Pub. L. 101–234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS

Pub. L. 100–360, title IV, §429, July 1, 1988, 102 Stat. 817, as amended by Pub. L. 100–647, title VIII, §8404(a), Nov. 10, 1988, 102 Stat. 3800, directed Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, to provide for at least 5 demonstration projects, for at least 3 years each, to review appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units.

RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES

Pub. L. 100–203, title IV, §4403, Dec. 22, 1987, 1330–226, as amended by Pub. L. 100–360, title IV, §411(m)(2)(A), July 1, 1988, 102 Stat. 806, provided that:

''(a) SET ASIDES FOR ISSUES OF HEALTH CARE IN RURAL AREAS AND IN INNER-CITY AREAS.—(1) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to rural health issues, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] on the financial viability of small rural hospitals, the effect of medicare payment policies on the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, the appropriateness of medicare conditions of participation and staffing requirements for small rural hospitals, and the impact of medicare policies on access to (and the quality of) health care in rural areas.

''(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas.

''(b) AGENDA.—The Secretary of Health and Human Services shall establish an agenda of research and demonstration projects, relating exclusively or substantially to rural health issues or to inner-city health issues, that are in progress or have been proposed, and shall include such agenda in the annual report submitted pursuant to section 1875(b) of the Social Security Act [42 U.S.C. 1395*ll*(b)]. The agenda shall be ac-

companied by a statement setting forth the amounts that have been obligated and expended with respect to such projects in the current and most recently completed fiscal years.''

ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS

Pub. L. 99–509, title IX, § 9342, Oct. 21, 1986, 100 Stat. 2038, as amended by Pub. L. 101–508, title IV, § 4164(a)(2), Nov. 5, 1990, 104 Stat. 1388–101; Pub. L. 103–66, title XIII, § 13552, Aug. 10, 1993, 107 Stat. 591, required Secretary of Health and Human Services to conduct at least 5 (and not more than 10) demonstration projects, each over a period of 5 years, to determine effectiveness, cost, and impact on health status and functioning of providing comprehensive services for individuals entitled to benefits under this subchapter who are victims of Alzheimer's disease or related disorders and to report to Congress upon completion of the projects.

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of waiver, see section 9202(j) of Pub. L. 99–272, as amended, set out as a note under section 1395ww of this title.

EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS

Pub. L. 99–272, title IX, § 9215, Apr. 7, 1986, 100 Stat. 180, as amended by Pub. L. 101–239, title VI, § 6135, Dec. 19, 1989, 103 Stat. 2222; Pub. L. 103–66, title XIII, § 13557, Aug. 10, 1993, 107 Stat. 592; Pub. L. 105–33, title IV, § 4017, Aug. 5, 1997, 111 Stat. 345; Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 534], Nov. 29, 1999, 113 Stat. 1536, 1501A–390; Pub. L. 106–554, § 1(a)(6) [title VI, § 633], Dec. 21, 2000, 114 Stat. 2763, 2763A–568; Pub. L. 108–173, title II, § 235, Dec. 8, 2003, 117 Stat. 2210, provided that:

''(a) The Secretary of Health and Human Services shall extend through December 31, 1997, approval of four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)]. The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, costs to the medicaid program and other payers, access to care, outcomes, beneficiary satisfaction, utilization differences among the different populations served by the projects, and such other factors as may be appropriate. Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2006, but only with respect to individuals who received at least one service during the period beginning on January 1, 1996, and ending on the date of the enactment of the Balanced Budget Act of 1997 [Aug. 5, 1997].

''(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project participants to a non-demonstration project health care delivery system, such as through integration with a private or public health plan, including a medicaid managed care or Medicare+Choice plan.

''(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of the Balanced Budget Act of 1997 [Aug. 5, 1997], shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project participants may be minimized.''

[References to Medicare+Choice deemed to refer to Medicare Advantage, see section 201(b) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.]

DEMONSTRATION PROGRAM FOR REDUCTION OF DISABILITY AND DEPENDENCY THROUGH PROVISION OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE

Pub. L. 99–272, title IX, § 9314, Apr. 7, 1986, 100 Stat. 194, as amended by Pub. L. 99–509, title IX, § 9344(d), Oct. 21, 1986, 100 Stat. 2042; Pub. L. 101–508, title IV, § 4164(a)(1), Nov. 5, 1990, 104 Stat. 1388–100, required Secretary of Health and Human Services to establish a 5-year demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under this subchapter and to submit reports to Congress including a final report on the project not later than April 1, 1995.

PAYMENT FOR COSTS OF HOSPITAL-BASED MOBILE INTENSIVE CARE UNITS

Pub. L. 98–369, div. B, title III, § 2320, July 18, 1984, 98 Stat. 1083, provided that:

''(a)(1) In the case of a project described in subsection (b), the Secretary of Health and Human Services shall provide, except as provided in paragraph (2), that the amount of payments to hospitals covered under the project during the period described in paragraph (3) shall include payments for their operation of hospital-based mobile intensive care units (as defined by State statute) if the State provides satisfactory assurances that the total amount of payments to such hospitals under titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] under the demonstration project (including any such additional amount of payment) would not exceed the total amount of payments which would have been paid under such titles if the demonstration project were not in effect.

''(2) Paragraph (1) shall not apply if the State in which the project is located notifies the Secretary, within 30 days after the date of the enactment of this section [July 18, 1984], that the State does not want paragraph (1) to apply to that project.

''(3) The period referred to in paragraph (1) begins on the date of the enactment of this section and continues so long as the Secretary continues the Statewide waiver referred to in subsection (b), but in no case ends earlier than 90 days after the date final regulations to implement section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] are published.

''(b) The project referred to in subsection (a) is the statewide demonstration project established in the State of New Jersey under section 402 of the Social Security Amendments of 1967, as amended by section 222(b) of the Social Security Amendments of 1972 (Public Law 92–603) [42 U.S.C. 1395b–1], which project provides for payments to hospitals in the State on a prospective basis and related to a classification of patients by diagnosis-related groups.

''(c) Payment for services described in this section shall be considered to be payments for services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.].''

CONTINUATION OF SECRETARY'S AUTHORITY REGARDING EXPERIMENTS AND DEMONSTRATION PROJECTS

Pub. L. 98–21, title VI, § 603(b), Apr. 20, 1983, 97 Stat. 167, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this title [amending sections 1320a–1, 1320c–2, 1395f, 1395i–2, 1395n, 1395r, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395*oo*, 1395rr, 1395ww, and 1395xx of this title, enacting provisions set out as notes under this section and sections 1395r, 1395x, 1395y, 1395cc, and 1395ww of this title, and amending provisions set out as a note under section 1395x of this title] shall not affect the authority of the Secretary to develop, carry out, or continue experiments and demonstration projects.

''(2) The Secretary shall provide that, upon the request of a State which has a demonstration project, for

payment of hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] approved under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)] or section 222(a) of the Social Security Amendments of 1972 [set out as a note below], which (A) is in effect as of March 1, 1983, and (B) was entered into after August 1982 (or upon the request of another party to demonstration project agreement), the terms of the demonstration agreement shall be modified so that the demonstration project is not required to maintain the rate of increase in medicare hospital costs in that State below the national rate of increase in medicare hospital costs.''

ALTERNATIVE CARE DEMONSTRATION PROJECTS IN HOSPITALS SHORT OF SKILLED NURSING FACILITIES

Pub. L. 98–21, title VI, §603(d), Apr. 20, 1983, 97 Stat. 168, provided that: ''The Secretary shall conduct demonstrations with hospitals in areas with critical shortages of skilled nursing facilities to study the feasibility of providing alternative systems of care or methods of payment.''

CONTINUATION OF HOSPICE DEMONSTRATION PROJECTS; REPORT TO CONGRESS

Pub. L. 97–248, title I, §122(i), formerly §122(h), Sept. 3, 1982, 96 Stat. 362, as redesignated and amended by Pub. L. 97–448, title III, §309(a)(6), (e), Jan. 12, 1983, 96 Stat. 2408, 2410, provided that:

''(1) Notwithstanding any provision of law which has the effect of restricting the time period of a hospice demonstration project in effect on July 15, 1982, pursuant to section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of the project until November 1, 1983, or, if later, the date on which payments can first be made to any hospice program under the amendments made by this section.

''(2) Prior to September 30, 1983, the Secretary shall submit to Congress a report on the effectiveness of demonstration projects referred to in paragraph (1), including an evaluation of the cost-effectiveness of hospice care, the reasonableness of the 40-percent cap amount for hospice care as provided in section 1814(i) of the Social Security Act [42 U.S.C. 1395f(i)] (as added by this section), proposed methodology for determining such cap amount, proposed standards for requiring and measuring the maintenance of effort for utilizing volunteers as required under section 1861(dd) of such Act [42 U.S.C. 1395x(dd)], an evaluation of physician reimbursement for services furnished as a part of hospice care and for services furnished to individuals receiving hospice care but which are not reimbursed as a part of the hospice care, and any proposed legislative changes in the hospice care provisions of title XVIII of such Act [42 U.S.C. 1395 et seq.].

''(3)(A) Notwithstanding the provisions of paragraph (1), the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of a hospice demonstration project described in paragraph (1) until September 30, 1986, if the hospice involved in such demonstration project does not provide hospice care directly but acts as a channeling agency for the provision of hospice care.

''(B) During the period after the date on which a hospice demonstration project described in subparagraph (A) would otherwise have terminated under the provisions of paragraph (1), and prior to September 30, 1986, any such hospice demonstration project shall be subject to the same requirements as are imposed under the hospice program provided for under the amendments made by this section [amending sections 1395c to 1395f, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacting provisions set out as notes under sections 1395c and 1395f of this title] with respect to reimbursement and benefits, other than the requirement that certain benefits be provided directly by the hospice involved.''

STATE MEDICARE HOSPITAL REIMBURSEMENT DEMONSTRATION PROJECT LIMITATION

Pub. L. 96–499, title IX, §903(c), Dec. 5, 1980, 94 Stat. 2615, which provided for a maximum number of six Statewide medicare hospital reimbursement demonstration projects, was repealed by Pub. L. 97–35, title XXI, §2154, Aug. 13, 1981, 95 Stat. 802.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

Pub. L. 96–499, title IX, §919, Dec. 5, 1980, 94 Stat. 2627, required study of need for dual participation of skilled nursing facilities and submission of a report and recommendations to Congress within one year after Dec. 5, 1980.

DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS IN URBAN MEDICALLY UNDERSERVED AREAS; REPORT SUBMITTED NO LATER THAN JANUARY 1, 1981

Pub. L. 95–210, §3, Dec. 13, 1977, 91 Stat. 1489, required the Secretary to provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under this subchapter and, notwithstanding any other provision of this subchapter, for services provided by a physician assistant or nurse practitioner employed by such clinics which would otherwise be covered under this subchapter if provided by a physician. The Secretary was to evaluate the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing a physician assistant or nurse practitioner, the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics, the appropriate definition for such clinics, the appropriate criteria to use for the purposes of designating urban medically underserved areas, and such other possible changes in the provisions of this subchapter as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics. Grants, payments under contracts, and other expenditures made for demonstration projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The Secretary was to submit to the Congress, no later than Jan. 1, 1981, a complete detailed report on the demonstration projects.

SCOPE OF GRANTS FOR EXPERIMENTS AND DEMONSTRATION PROJECTS TO DETERMINE METHODS FOR PROSPECTIVE PAYMENTS TO HOSPITALS, SKILLED NURSING FACILITIES, AND OTHER PROVIDERS OF SERVICES

Pub. L. 94–182, title I, §107, Dec. 31, 1975, 89 Stat. 1053, provided that: ''Nothing contained in section 222(a) of Public Law 92–603 [set out below] shall be construed to preclude or prohibit the Secretary of Health, Education, and Welfare [now Health and Human Services] from including in any grant otherwise authorized to be made under such section moneys which are to be used for payments, to a participant in a demonstration or experiment with respect to which the grant is made, for or on account of costs incurred or services performed by such participant for a period prior to the date that the project of such participant is placed in operation, if—

''(1) the applicant for such grant is a State or an agency thereof,

''(2) such participant is an individual practice association which has been in existence for at least 3 years prior to the date of enactment of this section [Dec. 31, 1975] and which has in effect a contract with such State (or an agency thereof), entered into prior to the date on which the grant is approved by the Secretary, under which such association will, for a period which begins before and ends after the date such grant is so approved, provide health care services for individuals entitled to care and services

under the State plan of such State which is approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.],

''(3) the purpose of the inclusion of the project of such association is to test the utility of a particular rate-setting methodology, designed to be employed in prepaid health plans, in an individual practice association operation, and

''(4) the applicant for such grant affirms that the use of moneys from such grant to make such payments to such individual practice association is necessary or useful in assuring that such association will be able to continue in operation and carry out the project described in clause (3).''

EXPERIMENTS AND DEMONSTRATION PROJECTS TO DETERMINE METHODS FOR PROSPECTIVE PAYMENTS TO HOSPITALS, SKILLED NURSING FACILITIES, AND OTHER PROVIDERS OF SERVICES FOR CARE AND SERVICES FURNISHED; SCOPE; WAIVER OF PAYMENT REQUIREMENTS; SOURCE AND MANNER OF PAYMENTS FOR GRANTS, ETC.; REPORTS TO CONGRESS

Pub. L. 92–603, title II, § 222(a), Oct. 30, 1972, 86 Stat. 1390, as amended by Pub. L. 97–35, title XXI, § 2193(e), Aug. 13, 1981, 95 Stat. 828, provided that:

''(1) The Secretary of Health, Education, and Welfare [now Health and Human Services], directly or through contracts with, or grants to, public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, skilled nursing facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and under State plans approved under title XIX of such Act [42 U.S.C. 1396 et seq.], including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive (or negative) financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

''(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

''(3) In the case of any experiment or demonstration project under paragraph (1), the Secretary may waive compliance with the requirements of titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] insofar as such requirements relate to methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles [subchapters] may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects already completed or in process; and no such experiment or project shall be actually placed in operation unless at least 30 days prior thereto a written report, prepared for purposes of notification and information only, containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

''(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act [42 U.S.C. 1395i]) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act [42 U.S.C. 1395t]) and from funds appropriated under title XIX of such Act [42 U.S.C. 1396 et seq.]. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such title XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

''(5) The Secretary shall submit to the Congress no later than July 1, 1974, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to prospective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.''

§ 1395b–2. Notice of medicare benefits; medicare and medigap information

(a) Notice of medicare benefits

The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this subchapter and the major categories of health care for which benefits are not available under this subchapter,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this subchapter, and

(3) a description of the limited benefits for long-term care services available under this subchapter and generally available under State plans approved under subchapter XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this subchapter and when an individual applies for benefits under part A or enrolls under part B.

(b) Medicare and medigap information

The Secretary shall provide information via a toll-free telephone number on the programs under this subchapter. The Secretary shall provide, through the toll-free telephone number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice

under subsection (a) instead of the listing of numbers of individual contractors.

(c) Contents of notice

The notice provided under subsection (a) shall include—

(1) a statement which indicates that because errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1395b–7 of this title for accuracy and report any errors or questionable charges by calling the toll-free phone number described in paragraph (4);

(2) a statement of the beneficiary's right to request an itemized statement for medicare items and services (as provided in section 1395b–7(b) of this title);

(3) a description of the program to collect information on medicare fraud and abuse established under section 1395b–5(b) of this title; and

(4) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this subchapter.

(d) Medicare opioid safety education

The notice provided under subsection (a) shall include—

(1) references to educational resources regarding opioid use and pain management;

(2) a description of categories of alternative, non-opioid pain management treatments covered under this subchapter; and

(3) a suggestion for the beneficiary to talk to a physician regarding opioid use and pain management.

(Aug. 14, 1935, ch. 531, title XVIII, § 1804, as added Pub. L. 100–360, title II, § 223(a), July 1, 1988, 102 Stat. 747; amended Pub. L. 103–432, title I, § 171(j)(1), Oct. 31, 1994, 108 Stat. 4450; Pub. L. 105–33, title IV, § 4311(a)(1), Aug. 5, 1997, 111 Stat. 384; Pub. L. 108–173, title IX, § 923(d)(1), Dec. 8, 2003, 117 Stat. 2394; Pub. L. 115–271, title VI, § 6021(a), Oct. 24, 2018, 132 Stat. 3977.)

Editorial Notes

AMENDMENTS

2018—Subsec. (d). Pub. L. 115–271 added subsec. (d).

2003—Subsec. (b). Pub. L. 108–173 inserted at end ''The Secretary shall provide, through the toll-free telephone number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''

1997—Subsec. (c). Pub. L. 105–33 added subsec. (c).

1994—Pub. L. 103–432 inserted ''; medicare and medigap information'' in section catchline, designated existing provisions as subsec. (a), and added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title VI, § 6021(b), Oct. 24, 2018, 132 Stat. 3977, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to notices distributed prior to each Medicare open enrollment period beginning after January 1, 2019.''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4311(a)(2), Aug. 5, 1997, 111 Stat. 384, provided that: ''The amendment made by this subsection [amending this section] shall apply to notices provided on or after January 1, 1998.''

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 171(*l*) of Pub. L. 103–432, set out as a note under section 1395ss of this title.

EFFECTIVE DATE

Pub. L. 100–360, title II, § 223(d)(1), July 1, 1988, 102 Stat. 748, provided that: ''The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) [enacting this section] not later than January 31, 1989.''

MONITORING ACCURACY

Pub. L. 108–173, title IX, § 923(d)(2), Dec. 8, 2003, 117 Stat. 2395, provided that:

''(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A [probably means part A of title XVIII of the Social Security Act which is classified to part A of this subchapter] or enrolled under part B [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], or both, through the toll-free telephone number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

''(B) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).''

STATE REGULATORY PROGRAMS

For provisions relating to changes required to conform State regulatory programs to amendments by section 171 of Pub. L. 103–432, see section 171(m) of Pub. L. 103–432, set out as a note under section 1395ss of this title.

DEMONSTRATION PROJECTS

Pub. L. 101–508, title IV, § 4361(b), Nov. 5, 1990, 104 Stat. 1388–141, provided that: ''The Secretary of Health and Human Services is authorized to conduct demonstration projects in up to 5 States for the purpose of establishing statewide toll-free telephone numbers for providing information on medicare benefits, medicare supplemental policies available in the State, and benefits under the State medicaid program.''

NOTICE OF CHANGES UNDER REPEAL OF MEDICARE CATASTROPHIC COVERAGE

Pub. L. 101–234, title II, § 203(c), Dec. 13, 1989, 103 Stat. 1984, provided that: ''The Secretary of Health and Human Services shall provide, in the notice of medicare benefits provided under section 1804 of the Social Security Act [42 U.S.C. 1395b–2] for 1990, for a description of the changes in benefits under title XVIII of such Act [42 U.S.C. 1395 et seq.] made by the amendments made by this Act [see Tables for classification].''

BENEFITS COUNSELING AND ASSISTANCE DEMONSTRATION PROJECT FOR CERTAIN MEDICARE AND MEDICAID BENEFICIARIES

Pub. L. 100–360, title IV, § 424, July 1, 1988, 102 Stat. 812, which directed Secretary of Health and Human

Services to establish a demonstration project to demonstrate that its volunteers were adequately trained and competent to render effective benefits counseling and assistance to the elderly, was repealed by Pub. L. 101–234, title III, § 301(a), Dec. 13, 1989, 103 Stat. 1985.

§ 1395b–3. Health insurance advisory service for medicare beneficiaries

(a) In general

The Secretary of Health and Human Services shall establish a health insurance advisory service program (in this section referred to as the ''beneficiary assistance program'') to assist medicare-eligible individuals with the receipt of services under the medicare and medicaid programs and other health insurance programs.

(b) Outreach elements

The beneficiary assistance program shall provide assistance—

(1) through operation using local Federal offices that provide information on the medicare program,

(2) using community outreach programs, and

(3) using a toll-free telephone information service.

(c) Assistance provided

The beneficiary assistance program shall provide for information, counseling, and assistance for medicare-eligible individuals with respect to at least the following:

(1) With respect to the medicare program—

(A) eligibility,

(B) benefits (both covered and not covered),

(C) the process of payment for services,

(D) rights and process for appeals of determinations,

(E) other medicare-related entities (such as peer review organizations, fiscal intermediaries, and carriers), and

(F) recent legislative and administrative changes in the medicare program.

(2) With respect to the medicaid program—

(A) eligibility, benefits, and the application process,

(B) linkages between the medicaid and medicare programs, and

(C) referral to appropriate State and local agencies involved in the medicaid program.

(3) With respect to medicare supplemental policies—

(A) the program under section 1395ss of this title and standards required under such program,

(B) how to make informed decisions on whether to purchase such policies and on what criteria to use in evaluating different policies,

(C) appropriate Federal, State, and private agencies that provide information and assistance in obtaining benefits under such policies, and

(D) other issues deemed appropriate by the Secretary.

The beneficiary assistance program also shall provide such other services as the Secretary deems appropriate to increase beneficiary understanding of, and confidence in, the medicare program and to improve the relationship between beneficiaries and the program.

(d) Educational material

The Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall develop appropriate educational materials and other appropriate techniques to assist employees in carrying out this section.

(e) Notice to beneficiaries

The Secretary shall take such steps as are necessary to assure that medicare-eligible beneficiaries and the general public are made aware of the beneficiary assistance program.

(f) Report

The Secretary shall include, in an annual report transmitted to the Congress, a report on the beneficiary assistance program and on other health insurance informational and counseling services made available to medicare-eligible individuals. The Secretary shall include in the report recommendations for such changes as may be desirable to improve the relationship between the medicare program and medicare-eligible individuals.

(Pub. L. 101–508, title IV, § 4359, Nov. 5, 1990, 104 Stat. 1388–137; Pub. L. 108–173, title IX, § 900(e)(6)(G), Dec. 8, 2003, 117 Stat. 2374.)

Editorial Notes

CODIFICATION

Section was enacted as part of the Omnibus Budget Reconciliation Act of 1990, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

2003—Subsec. (d). Pub. L. 108–173 substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Statutory Notes and Related Subsidiaries

STATE HEALTH INSURANCE ASSISTANCE PROGRAM REPORTING REQUIREMENTS

Pub. L. 115–123, div. E, title II, § 50207(b), Feb. 9, 2018, 132 Stat. 187, provided that: ''Beginning not later than April 1, 2019, and biennially thereafter, the Agency for Community Living [probably means the Administration for Community Living] shall electronically post on its website the following information, with respect to grants to States for State health insurance assistance programs, (such information to be presented by State and by entity receiving funds from the State to carry out such a program funded by such grant):

''(1) The amount of Federal funding provided to each such State for such program for the period involved and the amount of Federal funding provided by each such State for such program to each such entity for the period involved.

''(2) Information as the Secretary may specify, with respect to such programs carried out through such grants, consistent with the terms and conditions for receipt of such grants.''

MEDICARE ENROLLMENT ASSISTANCE

Pub. L. 110–275, title I, § 119, July 15, 2008, 122 Stat. 2508, as amended by Pub. L. 111–148, title III, § 3306, Mar. 23, 2010, 124 Stat. 470; Pub. L. 112–240, title VI, § 610, Jan. 2, 2013, 126 Stat. 2351; Pub. L. 113–67, div. B, title I, § 1110, Dec. 26, 2013, 127 Stat. 1198; Pub. L. 113–93, title I, § 110, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, § 208, Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E,

title II, § 50207(a), Feb. 9, 2018, 132 Stat. 186; Pub. L. 116–59, div. B, title IV, § 1402, Sept. 27, 2019, 133 Stat. 1106; Pub. L. 116–69, div. B, title IV, § 1402, Nov. 21, 2019, 133 Stat. 1138; Pub. L. 116–94, div. N, title I, § 103, Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, § 3803(a), Mar. 27, 2020, 134 Stat. 428; Pub. L. 116–159, div. C, title II, § 2203, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, § 1102, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. CC, title I, § 103, Dec. 27, 2020, 134 Stat. 2942, provided that:

''(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall use amounts made available under subparagraph (B) to make grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 [42 U.S.C. 1395b–4].

''(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

''(i) for fiscal year 2009, of $7,500,000;

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000;

''(iii) for fiscal year 2013, of $7,500,000;

''(iv) for fiscal year 2014, of $7,500,000;

''(v) for fiscal year 2015, of $7,500,000;

''(vi) for fiscal year 2016, of $13,000,000;

''(vii) for fiscal year 2017, of $13,000,000;

''(viii) for fiscal year 2018, of $13,000,000;

''(ix) for fiscal year 2019, of $13,000,000;

''(x) for fiscal year 2020, of $13,000,000;

''(xi) for fiscal year 2021, $15,000,000;

''(xii) for fiscal year 2022, $15,000,000; and

''(xiii) for fiscal year 2023, $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

''(2) AMOUNT OF GRANTS.—The amount of a grant to a State under this subsection from the total amount made available under paragraph (1) shall be equal to the sum of the amount allocated to the State under paragraph (3)(A) and the amount allocated to the State under subparagraph (3)(B).

''(3) ALLOCATION TO STATES.—

''(A) ALLOCATION BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅔ of the total amount made available under paragraph (1) shall be based on the number of individuals who meet the requirement under subsection (a)(3)(A)(ii) of section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) but who have not enrolled to receive a subsidy under such section 1860D–14 relative to the total number of individuals who meet the requirement under such subsection (a)(3)(A)(ii) in each State, as estimated by the Secretary.

''(B) ALLOCATION BASED ON PERCENTAGE OF RURAL BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅓ of the total amount made available under paragraph (1) shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of such Act (42 U.S.C. 1395w–101(a)(3)(A))) residing in a rural area relative to the total number of such individuals in each State, as estimated by the Secretary.

''(4) PORTION OF GRANT BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES TO BE USED TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Each grant awarded under this subsection with respect to amounts allocated under paragraph (3)(A) shall be used to provide outreach to individuals who may be subsidy eligible individuals (as defined in section 1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(A))[)] or eligible for the Medicare Savings Program (as defined in subsection (f)).

''(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Aging, shall make grants to States for area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)) and Native American programs carried out under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.).

''(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $7,500,000;

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000;

''(iii) for fiscal year 2013, of $7,500,000;

''(iv) for fiscal year 2014, of $7,500,000;

''(v) for fiscal year 2015, of $7,500,000;

''(vi) for fiscal year 2016, of $7,500,000;

''(vii) for fiscal year 2017, of $7,500,000;

''(viii) for fiscal year 2018, of $7,500,000;

''(ix) for fiscal year 2019, of $7,500,000;

''(x) for fiscal year 2020, of $7,500,000;

''(xi) for fiscal year 2021, $15,000,000;

''(xii) for fiscal year 2022, $15,000,000; and

''(xiii) for fiscal year 2023, $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

''(2) AMOUNT OF GRANT AND ALLOCATION TO STATES BASED ON PERCENTAGE OF LOW-INCOME AND RURAL BENEFICIARIES.—The amount of a grant to a State under this subsection from the total amount made available under paragraph (1) shall be determined in the same manner as the amount of a grant to a State under subsection (a), from the total amount made available under paragraph (1) of such subsection, is determined under paragraph (2) and subparagraphs (A) and (B) of paragraph (3) of such subsection.

''(3) REQUIRED USE OF FUNDS.—

''(A) ALL FUNDS.—Subject to subparagraph (B), each grant awarded under this subsection shall be used to provide outreach to eligible Medicare beneficiaries regarding the benefits available under title XVIII of the Social Security Act [this subchapter].

''(B) OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Subsection (a)(4) shall apply to each grant awarded under this subsection in the same manner as it applies to a grant under subsection (a).

''(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Secretary shall make grants to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program that are established centers under such program on the date of the enactment of this Act [July 15, 2008].

''(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Sup-

plementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000;

''(ii) for the period of fiscal years 2010 through 2012, of $10,000,000;

''(iii) for fiscal year 2013, of $5,000,000;

''(iv) for fiscal year 2014, of $5,000,000;

''(v) for fiscal year 2015, of $5,000,000;

''(vi) for fiscal year 2016, of $5,000,000;

''(vii) for fiscal year 2017, of $5,000,000;

''(viii) for fiscal year 2018, of $5,000,000;

''(ix) for fiscal year 2019, of $5,000,000;

''(x) for fiscal year 2020, of $5,000,000;

''(xi) for fiscal year 2021, $5,000,000;

''(xii) for fiscal year 2022, $5,000,000; and

''(xiii) for fiscal year 2023, $5,000,000, [probably should be a period]

Amounts appropriated under this subparagraph shall remain available until expended.

''(2) REQUIRED USE OF FUNDS.—Each grant awarded under this subsection shall be used to provide outreach to individuals regarding the benefits available under the Medicare prescription drug benefit under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] and under the Medicare Savings Program.

''(d) COORDINATION OF EFFORTS TO INFORM OLDER AMERICANS ABOUT BENEFITS AVAILABLE UNDER FEDERAL AND STATE PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Aging, in cooperation with related Federal agency partners, shall make a grant to, or enter into a contract with, a qualified, experienced entity under which the entity shall—

''(A) maintain and update web-based decision support tools, and integrated, person-centered systems, designed to inform older individuals (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)) about the full range of benefits for which the individuals may be eligible under Federal and State programs;

''(B) utilize cost-effective strategies to find older individuals with the greatest economic need (as defined in such section 102) and inform the individuals of the programs;

''(C) develop and maintain an information clearinghouse on best practices and the most cost-effective methods for finding older individuals with greatest economic need and informing the individuals of the programs; and

''(D) provide, in collaboration with related Federal agency partners administering the Federal programs, training and technical assistance on the most effective outreach, screening, and follow-up strategies for the Federal and State programs.

''(2) FUNDING.—For purposes of making a grant or entering into a contract under paragraph (1), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000;

''(ii) for the period of fiscal years 2010 through 2012, of $5,000,000;

''(iii) for fiscal year 2013, of $5,000,000;

''(iv) for fiscal year 2014, of $5,000,000;

''(v) for fiscal year 2015, of $5,000,000;

''(vi) for fiscal year 2016, of $12,000,000;

''(vii) for fiscal year 2017, of $12,000,000;

''(viii) for fiscal year 2018, of $12,000,000;

''(ix) for fiscal year 2019, of $12,000,000;

''(x) for fiscal year 2020, of $12,000,000;

''(xi) for fiscal year 2021, $15,000,000;

''(xii) for fiscal year 2022, $15,000,000; and

''(xiii) for fiscal year 2023, $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

''(e) REPROGRAMMING FUNDS FROM MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007.—The Secretary shall only use the $5,000,000 in funds allocated to make grants to States for Area Agencies on Aging and Aging Disability and Resource Centers for the period of fiscal years 2008 through 2009 under section 118 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [121 Stat. 2508] for the sole purpose of providing outreach to individuals regarding the benefits available under the Medicare prescription drug benefit under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]. The Secretary shall republish the request for proposals issued on April 17, 2008, in order to comply with the preceding sentence.

''(f) MEDICARE SAVINGS PROGRAM DEFINED.—For purposes of this section, the term 'Medicare Savings Program' means the program of medical assistance for payment of the cost of medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933 of the Social Security Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).

''(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection [probably should be ''section''] to support the conduct of activities described in the preceding sentence.''

[Pub. L. 116–136, div. A, title III, § 3803(b), Mar. 27, 2020, 134 Stat. 429, provided that: ''The amendments made by subsection (a) [amending section 119 of Pub. L. 110–275, set out above] shall take effect as if included in the enactment of the Further Consolidated Appropriations Act, 2020 (Public Law 116–94).'']

BENEFICIARY OUTREACH DEMONSTRATION PROGRAM

Pub. L. 108–173, title IX, § 924, Dec. 8, 2003, 117 Stat. 2395, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a demonstration program (in this section referred to as the 'demonstration program') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.], or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

''(b) LOCATIONS.—

''(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

''(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

''(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

''(d) EVALUATION AND REPORT.—

''(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

''(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

''(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

''(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.''

QUALIFIED MEDICARE BENEFICIARY OUTREACH

Pub. L. 103–432, title I, §154, Oct. 31, 1994, 108 Stat. 4437, provided that not later than 1 year after Oct. 31, 1994, the Secretary of Health and Human Services would establish and implement a method for obtaining information from newly eligible medicare beneficiaries that might be used to determine whether such beneficiaries may be eligible for medical assistance for medicare cost-sharing under State medicaid plans as qualified medicare beneficiaries, and for transmitting such information to the State in which such a beneficiary resides.

§ 1395b–4. Health insurance information, counseling, and assistance grants

(a) Grants

The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make grants to States, with approved State regulatory programs under section 1395ss of this title, that submit applications to the Secretary that meet the requirements of this section for the purpose of providing information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage to individuals who are eligible to receive benefits under this subchapter (in this section referred to as ''eligible individuals''). The Secretary shall prescribe regulations to establish a minimum level of funding for a grant issued under this section.

(b) Grant applications

(1) In submitting an application under this section, a State may consolidate and coordinate an application that consists of parts prepared by more than one agency or department of such State.

(2) As part of an application for a grant under this section, a State shall submit a plan for a State-wide health insurance information, counseling, and assistance program. Such program shall—

(A) establish or improve upon a health insurance information, counseling, and assistance program that provides counseling and assistance to eligible individuals in need of health insurance information, including—

(i) information that may assist individuals in obtaining benefits and filing claims under this subchapter and subchapter XIX of this chapter;

(ii) policy comparison information for medicare supplemental policies (as described in section 1395ss(g)(1) of this title) and information that may assist individuals in filing claims under such medicare supplemental policies;

(iii) information regarding long-term care insurance; and

(iv) information regarding other types of health insurance benefits that the Secretary determines to be appropriate;

(B) in conjunction with the health insurance information, counseling, and assistance program described in subparagraph (A), establish a system of referral to appropriate Federal or State departments or agencies for assistance with problems related to health insurance coverage (including legal problems), as determined by the Secretary;

(C) provide for a sufficient number of staff positions (including volunteer positions) necessary to provide the services of the health insurance information, counseling, and assistance program;

(D) provide assurances that staff members (including volunteer staff members) of the health insurance information, counseling, and assistance program have no conflict of interest in providing the counseling described in subparagraph (A);

(E) provide for the collection and dissemination of timely and accurate health care information to staff members;

(F) provide for training programs for staff members (including volunteer staff members);

(G) provide for the coordination of the exchange of health insurance information between the staff of departments and agencies of the State government and the staff of the health insurance information, counseling, and assistance program;

(H) make recommendations concerning consumer issues and complaints related to the provision of health care to agencies and departments of the State government and the Federal Government responsible for providing or regulating health insurance;

(I) establish an outreach program to provide the health insurance information and counseling described in subparagraph (A) and the referrals described in subparagraph (B) to eligible individuals; and

(J) demonstrate, to the satisfaction of the Secretary, an ability to provide the counseling and assistance required under this section.

(c) Special grants

(1) A State that is conducting a health insurance information, counseling, and assistance program that is substantially similar to a program described in subsection (b)(2) shall, as a requirement for eligibility for a grant under this section, demonstrate, to the satisfaction of the Secretary, that such State shall maintain the activities of such program at least at the level that such activities were conducted immediately preceding the date of the issuance of any grant during the period of time covered by such grant under this section.

(2) If the Secretary determines that the existing health insurance information, counseling, and assistance program is substantially similar to a program described in subsection (b)(2), the Secretary may waive some or all of the requirements described in such subsection and issue a grant to the State for the purpose of increasing the number of services offered by the health insurance information, counseling, and assistance program, experimenting with new methods of outreach in conducting such program, or expanding such program to geographic areas of the State not previously served by the program.

(d) Criteria for issuing grants

In issuing a grant under this section, the Secretary shall consider—

(1) the commitment of the State to carrying out the health insurance information, counseling, and assistance program described in subsection (b)(2), including the level of cooperation demonstrated—

(A) by the office of the chief insurance regulator of the State, or the equivalent State entity;

(B) other officials of the State responsible for overseeing insurance plans issued by nonprofit hospital and medical service associations; and

(C) departments and agencies of such State responsible for—

(i) administering funds under subchapter XIX of this chapter, and

(ii) administering funds appropriated under the Older Americans Act [42 U.S.C. 3001 et seq.];

(2) the population of eligible individuals in such State as a percentage of the population of such State; and

(3) in order to ensure the needs of rural areas in such State, the relative costs and special problems associated with addressing the special problems of providing health care information, counseling, and assistance eligible[1] individuals residing in rural areas of such State.

(e) Annual State report

A State that receives a grant under this section shall, not later than 180 days after receiving such grant, and annually thereafter during the period of the grant, issue a report to the Secretary that includes information concerning—

(1) the number of individuals served by the health insurance information, counseling and assistance program of such State;

(2) an estimate of the amount of funds saved by the State, and by eligible individuals in the State, in the implementation of such program; and

(3) the problems that eligible individuals in such State encounter in procuring adequate and appropriate health care coverage.

(f) Report to Congress

Beginning with 1992, and annually thereafter, the Secretary shall issue a report to the Committee on Finance of the Senate, the Special Committee on Aging of the Senate, the Committee on Ways and Means of the House of Representatives, and the Committee on Energy and Commerce of the House of Representatives that—

(1) summarizes the allocation of funds authorized for grants under this section and the expenditure of such funds;

(2) outlines the problems that eligible individuals encounter in procuring adequate and appropriate health care coverage;

(3) makes recommendations that the Secretary determines to be appropriate to address the problems described in paragraph (3);[2] and

(4) in the case of the report issued 2 years after November 5, 1990, evaluates the effectiveness of counseling programs established under this program, and makes recommendations regarding continued authorization of funds for these purposes.

(g) Authorization of appropriations for grants

There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $10,000,000 for each of fiscal years 1991, 1992, 1993, 1994, 1995, and 1996, to fund the grant programs described in this section.

(Pub. L. 101–508, title IV, § 4360, Nov. 5, 1990, 104 Stat. 1388–138; Pub. L. 103–432, title I, § 171(i), Oct. 31, 1994, 108 Stat. 4450; Pub. L. 103–437, § 15(b), Nov. 2, 1994, 108 Stat. 4591; Pub. L. 105–362, title VI, § 602(b)(2), Nov. 10, 1998, 112 Stat. 3286.)

Editorial Notes

REFERENCES IN TEXT

The Older Americans Act, referred to in subsec. (d)(1)(C)(ii), probably means the Older Americans Act of 1965, which is Pub. L. 89–73, July 14, 1965, 79 Stat. 218, as amended, and is classified generally to chapter 35 (§ 3001 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

CODIFICATION

Section was enacted as part of the Omnibus Budget Reconciliation Act of 1990, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

1998—Subsec. (f). Pub. L. 105–362 substituted ''Beginning with 1992'' for ''Not later than 180 days after November 5, 1990''.

1994—Subsec. (b)(2)(A)(ii). Pub. L. 103–432, § 171(i)(1), inserted closing parenthesis after ''of this title''.

Subsec. (b)(2)(D). Pub. L. 103–432, § 171(i)(2), substituted ''counseling'' for ''services'' before ''described in subparagraph (A)''.

Subsec. (b)(2)(I). Pub. L. 103–432, § 171(i)(3), substituted ''referrals'' for ''assistance''.

Subsec. (c)(1). Pub. L. 103–432, § 171(i)(4), struck out ''and that such activities will continue to be maintained at such level'' after ''covered by such grant under this section''.

Subsec. (d)(3). Pub. L. 103–432, § 171(i)(5), substituted ''eligible individuals residing in rural areas'' for ''to the rural areas''.

Subsec. (e). Pub. L. 103–432, § 171(i)(6)(A), (B), in introductory provisions, substituted ''this section'' for ''subsection (c) or (d) of this section'' and ''and annually thereafter during the period of the grant, issue a report'' for ''and annually thereafter, issue an annual report''.

Subsec. (e)(1). Pub. L. 103–432, § 171(i)(6)(C), struck out ''State-wide'' before ''health insurance information''.

Subsec. (f). Pub. L. 103–437, § 15(b)(1), in introductory provisions, substituted ''and the Committee on Energy and Commerce'' for ''the Committee on Energy and Commerce of the House of Representatives, and the Select Committee on Aging''.

Pub. L. 103–432, § 171(i)(8)(B), and Pub. L. 103–437, § 15(b)(2), made identical amendments, redesignating subsec. (f), relating to authorization of appropriations for grants, as (g).

Pub. L. 103–432, § 171(i)(8)(A), in subsec. (f), relating to authorization of appropriations for grants, substituted ''1993, 1994, 1995, and 1996'' for ''and 1993''.

Subsec. (f)(2) to (5). Pub. L. 103–432, § 171(i)(7), in subsec. (f), relating to report to Congress, redesignated

[1] So in original. Probably should be preceded by ''to''.

[2] So in original. Probably should be paragraph ''(2)''.

pars. (3) to (5) as (2) to (4), respectively, and struck out former par. (2) which read as follows: ''summarizes the scope and content of training conferences convened under this section;''.

Subsec. (g). Pub. L. 103–432, §171(i)(8)(B), and Pub. L. 103–437, §15(b)(2), made identical amendments, redesignating subsec. (f), relating to authorization of appropriations for grants, as (g).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104–14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 171(*l*) of Pub. L. 103–432, set out as a note under section 1395ss of this title.

DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED

Pub. L. 110–275, title I, §186, July 15, 2008, 122 Stat. 2588, provided that:

''(a) ESTABLISHMENT.—Within one year after the date of the enactment of this Act [July 15, 2008], the Secretary (in this section referred to as the 'Secretary') shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to medicare beneficiaries who were previously uninsured.

''(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq., 1395w–21 et seq.]. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the 'Welcome to Medicare' physical exam.

''(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

''(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

''(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

''(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.''

STATE REGULATORY PROGRAMS

For provisions relating to changes required to conform State regulatory programs to amendments by section 171 of Pub. L. 103–432, see section 171(m) of Pub. L. 103–432, set out as a note under section 1395ss of this title.

§ 1395b–5. Beneficiary incentive programs

(a) Repealed. Pub. L. 105–33, title IV, § 4311(b)(2), Aug. 5, 1997, 111 Stat. 386

(b) Program to collect information on fraud and abuse

(1) Establishment of program

Not later than 3 months after August 21, 1996, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging in or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1320a–7, 1320a–7a, or 1320a–7b of this title, or who have otherwise engaged in fraud and abuse against the Medicare program under this subchapter for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) Payment of portion of amounts collected

If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1320a–7b of this title), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) Program to collect information on program efficiency

(1) Establishment of program

Not later than 3 months after August 21, 1996, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program.

(2) Payment of portion of program savings

If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

(Pub. L. 104–191, title II, §203, Aug. 21, 1996, 110 Stat. 1998; Pub. L. 105–33, title IV, §4311(b)(2), Aug. 5, 1997, 111 Stat. 386.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(2), is classified generally to Title 26, Internal Revenue Code.

CODIFICATION

Section was enacted as part of the Health Insurance Portability and Accountability Act of 1996, and not as

part of the Social Security Act which comprises this chapter.

AMENDMENTS

1997—Subsec. (a). Pub. L. 105–33 struck out heading and text of subsec. (a). Text read as follows: ''The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall provide an explanation of benefits under the Medicare program under this subchapter with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.''

§ 1395b–6. Medicare Payment Advisory Commission

(a) Establishment

There is hereby established as an agency of Congress the Medicare Payment Advisory Commission (in this section referred to as the ''Commission'').

(b) Duties

(1) Review of payment policies and annual reports

The Commission shall—

(A) review payment policies under this subchapter, including the topics described in paragraph (2);

(B) make recommendations to Congress concerning such payment policies;

(C) by not later than March 15,[1] submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

(D) by not later than June 15 of each year, submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program and including a review of the estimate of the conversion factor submitted under section 1395w–4(d)(1)(E)(ii) of this title, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible.

(2) Specific topics to be reviewed

(A) Medicare+Choice program

Specifically, the Commission shall review, with respect to the Medicare+Choice program under part C, the following:

(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

(iii) The implications of risk selection both among Medicare+Choice organizations and between the Medicare+Choice option and the original medicare fee-for-service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare+Choice organizations.

(v) The impact of the Medicare+Choice program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the Medicare+Choice program.

(B) Original medicare fee-for-service system

Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

(ii) payment methodologies, and

(iii) their relationship to access and quality of care for medicare beneficiaries.

(C) Interaction of medicare payment policies with health care delivery generally

Specifically, the Commission shall review the effect of payment policies under this subchapter on the delivery of health care services other than under this subchapter and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

(3) Comments on certain secretarial reports

If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this subchapter, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

(4) Agenda and additional reviews

The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this subchapter as may be requested by such chairmen and members and as the Commission deems appropriate.

(5) Availability of reports

The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(6) Appropriate committees of Congress

For purposes of this section, the term ''appropriate committees of Congress'' means the

[1] So in original.

Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(7) Voting and reporting requirements

With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

(8) Examination of budget consequences

Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(9) Review and annual report on Medicaid and commercial trends

The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under subchapter XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1396 of this title (in this section referred to as ''MACPAC'').

(10) Coordinate and consult with the Federal Coordinated Health Care Office

The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081[2] of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(11) Interaction of Medicaid and Medicare

The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.

(c) Membership

(1) Number and appointment

The Commission shall be composed of 17 members appointed by the Comptroller General.

(2) Qualifications

(A) In general

The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) Inclusion

The membership of the Commission shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(C) Majority nonproviders

Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this subchapter shall not constitute a majority of the membership of the Commission.

(D) Ethical disclosure

The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) Terms

(A) In general

The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(4) Compensation

While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serv-

[2] See References in Text note below.

ing as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman

The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) Meetings

The Commission shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants

Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5 governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 6101 of title 41);

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(e) Powers

(1) Obtaining official data

The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(2) Data collection

In order to carry out its functions, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(3) Access of GAO to information

The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(4) Periodic audit

The Commission shall be subject to periodic audit by the Comptroller General.

(f) Authorization of appropriations

(1) Request for appropriations

The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) Authorization

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XVIII, § 1805, as added Pub. L. 105–33, title IV, § 4022(a), Aug. 5, 1997, 111 Stat. 350; amended Pub. L. 105–277, div. J, title V, § 5202(a), Oct. 21, 1998, 112 Stat. 2681–917; Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 211(a)(2)(B)], Nov. 29, 1999, 113 Stat. 1536, 1501A–347; Pub. L. 106–554, § 1(a)(6) [title V, § 544(a)(1), (b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–551; Pub. L. 108–173, title VII, § 735(a)–(c)(1), (e)(1), Dec. 8, 2003, 117 Stat. 2353, 2354; Pub. L. 110–173, title III, § 301, Dec. 29, 2007, 121 Stat. 2514; Pub. L. 111–148, title II, § 2801(b), title III, § 3403(c), Mar. 23, 2010, 124 Stat. 332, 507; Pub. L. 115–123, div. E, title XI, § 52001(b)(3), Feb. 9, 2018, 132 Stat. 298.)

Editorial Notes

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsec. (b)(10), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. The Act does not contain a section 2081. The Federal Coordinated Health Care Office is established in section 2602(a)(1) of the Act, which is classified to section 1315b(a)(1) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Ethics in Government Act of 1978, referred to in subsec. (c)(2)(D), is Pub. L. 95–521, Oct. 26, 1978, 92 Stat. 1824. Title I of the Act is set out in the Appendix to Title 5, Government Organization and Employees. For

complete classification of this Act to the Code, see Short Title note set out under section 101 of Pub. L. 95–521 in the Appendix to Title 5 and Tables.

CODIFICATION

In subsec. (d)(3), ''section 6101 of title 41'' substituted for ''section 3709 of the Revised Statutes (41 U.S.C. 5)'' on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2018—Subsec. (b)(4) to (9). Pub. L. 115–123 struck out par. (4), redesignated former pars. (5) to (8) as (4) to (7), respectively, and redesignated former par. (9) relating to examination of budget consequences as par. (8). Prior to amendment, par. (4) related to review and comment on proposals submitted to the Commission.

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §2801(b)(1), substituted ''March 15'' for ''March 1 of each year (beginning with 1998)''.

Subsec. (b)(1)(D). Pub. L. 111–148, §2801(b)(2), inserted '', and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible'' before the period.

Subsec. (b)(4). Pub. L. 111–148, §3403(c)(2), added par. (4). Former par. (4) redesignated (5).

Subsec. (b)(5) to (8). Pub. L. 111–148, §3403(c)(1), redesignated pars. (4) to (7) as (5) to (8), respectively. Former par. (8) relating to examination of budget consequences redesignated (9).

Subsec. (b)(9). Pub. L. 111–148, §3403(c)(1), redesignated par. (8) relating to examination of budget consequences as (9).

Pub. L. 111–148, §2801(b)(3), added par. (9) relating to review and annual report on Medicaid and commercial trends.

Subsec. (b)(10), (11). Pub. L. 111–148, §2801(b)(3), added pars. (10) and (11).

2007—Subsec. (a). Pub. L. 110–173 inserted ''as an agency of Congress'' after ''established''.

2003—Subsec. (b)(2)(B)(i). Pub. L. 108–173, §735(b), inserted ''the efficient provision of'' after ''expenditures for''.

Subsec. (b)(8). Pub. L. 108–173, §735(a), added par. (8).

Subsec. (c)(2)(B). Pub. L. 108–173, §735(e)(1), inserted ''experts in the area of pharmaco-economics or prescription drug benefit programs,'' after ''other health professionals,''.

Subsec. (c)(2)(D). Pub. L. 108–173, §735(c)(1), inserted at end ''Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).''

2000—Subsec. (b)(1)(D). Pub. L. 106–554, §1(a)(6) [title V, §544(a)(1)], substituted ''June 15 of each year,'' for ''June 1 of each year (beginning with 1998),''.

Subsec. (b)(7). Pub. L. 106–554, §1(a)(6) [title V, §544(b)], added par. (7).

1999—Subsec. (b)(1)(D). Pub. L. 106–113 inserted ''and including a review of the estimate of the conversion factor submitted under section 1395w–4(d)(1)(E)(ii) of this title'' before period at end.

1998—Subsec. (c)(1). Pub. L. 105–277 substituted ''17'' for ''15''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title VII, §735(c)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 2004.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §544(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–551, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply beginning with 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–113 effective in determining conversion factor under section 1395w–4(d) of this title for years beginning with 2001 and not applicable to or affecting any update (or any update adjustment factor) for any year before 2001, see section 1000(a)(6) [title II, §211(d)] of Pub. L. 106–113, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE; TRANSITION; TRANSFER OF FUNCTIONS

Pub. L. 105–33, title IV, §4022(c), Aug. 5, 1997, 111 Stat. 355, provided that:

''(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as 'MedPAC') by not later than September 30, 1997.

''(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed [Oct. 1, 1997, see 62 FR 52131], the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as 'ProPAC') and the Physician Payment Review Commission (in this subsection referred to as 'PPRC'), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions [Nov. 1, 1997, see 62 FR 59356], the amendments made by paragraphs (1) and (2), respectively, of subsection (b) [amending sections 1395w–4, 1395y, and 1395ww of this title and repealing section 1395w–1 of this title] become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

''(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.''

MEDPAC REVIEW OF PAYMENTS TO RURAL EMERGENCY HOSPITALS

Pub. L. 116–260, div. CC, title I, §125(f), Dec. 27, 2020, 134 Stat. 2966, provided that: ''Each report submitted by the Medicare Payment Advisory Commission under section 1805(b)(1)(C) of the Social Security Act (42 U.S.C. 1395b–6(b)(1)(C)) (beginning with 2024), shall include a review of payments to rural emergency hospitals under section 1834(x) [42 U.S.C. 1395m(x)], as added by subsection (a).''

APPOINTMENT OF EXPERTS IN PRESCRIPTION DRUGS

Pub. L. 108–173, title VII, §735(e)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: ''The Comptroller General of the United States shall ensure that the membership of the Commission [Medicare Payment Advisory Commission] complies with the amendment made by paragraph (1) [amending this section] with respect to appointments made on or after the date of the enactment of this Act [Dec. 8, 2003].''

MEDPAC ANALYSIS OF IMPACT OF VOLUME ON PER UNIT COST OF RURAL HOSPITALS WITH PSYCHIATRIC UNITS

Pub. L. 106–554, §1(a)(6) [title II, §214], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that: ''The Medicare

Payment Advisory Commission, in its study conducted pursuant to subsection (a) of section 411 of BBRA [Pub. L. 106–113, § 1000(a)(6) [title IV, § 411], set out as a note below] (113 Stat. 1501A–377), shall include—

''(1) in such study an analysis of the impact of volume on the per unit cost of rural hospitals with psychiatric units; and

''(2) in its report under subsection (b) of such section a recommendation on whether special treatment for such hospitals may be warranted.''

MEDPAC STUDY ON COMPLEXITY OF MEDICARE PROGRAM AND LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS

Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 229(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–357, required a comprehensive study related to regulatory burdens placed on health care providers and, no later than Dec. 31, 2001, a report and legislative recommendations.

MEDPAC REPORT

Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 312(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, provided that: ''The Medicare Payment Advisory Commission shall include in its report submitted to Congress in March of 2001 recommendations regarding the appropriateness of the initial residency period used under section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) for other residency training programs in a specialty that require preliminary years of study in another specialty.''

MEDPAC STUDY OF RURAL PROVIDERS

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 411], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, required a study evaluating the adequacy and appropriateness of the categories of special payments established for rural hospitals under the medicare program and a report to be submitted no later than 18 months after Nov. 29, 1999.

QUALITY IMPROVEMENT STANDARDS

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 520(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

''(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

''(B) the original medicare fee-for-service program under parts A and B [sic] title XVIII of such Act (42 U.S.C. 1395 et seq.) [42 U.S.C. 1395c et seq., 1395j et seq.].

''(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

''(3) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study.''

INITIAL TERMS OF ADDITIONAL MEMBERS

Pub. L. 105–277, div. J, title V, § 5202(b), Oct. 21, 1998, 112 Stat. 2681–917, provided that:

''(1) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission (under section 1805(c)(3) of such Act (42 U.S.C. 1395b–6(c)(3))[)], the initial terms of the two additional members of the Commission provided for by the amendment under subsection (a) [amending this section] are as follows:

''(A) One member shall be appointed for one year.

''(B) One member shall be appointed for two years.

''(2) COMMENCEMENT OF TERMS.—Such terms shall begin on May 1, 1999.''

INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS

Pub. L. 105–33, title IV, § 4804(c), Aug. 5, 1997, 111 Stat. 552, provided that: ''The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act [42 U.S.C. 1395b–6(b)(1)(B)] recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act [42 U.S.C. 1395eee(d), 1396u–4(d)] and on the treatment of private, for-profit entities as PACE providers.''

§ 1395b–7. Explanation of medicare benefits

(a) In general

The Secretary shall furnish to each individual for whom payment has been made under this subchapter (or would be made without regard to any deductible) a statement which—

(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b)).

(b) Request for itemized statement for medicare items and services

(1) In general

An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this subchapter.

(2) 30-day period to furnish statement

(A) In general

Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

(B) Penalty

Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(3) Review of itemized statement

(A) In general

Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

(B) Specific allegations

A request for a review of the itemized statement shall identify—

(i) specific items or services that the individual believes were not provided as claimed, or

(ii) any other billing irregularity (including duplicate billing).

(4) Findings of Secretary

The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this subchapter.

(5) Recovery of amounts

The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this subchapter with respect to a statement described in paragraph (4).

(c) Format of statements from Secretary

(1) Electronic option beginning in 2016

Subject to paragraph (2), for statements described in subsection (a) that are furnished for a period in 2016 or a subsequent year, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such a format and shall not be mailed to the individual.

(2) Limitation on revocation option

(A) In general

Subject to subparagraph (B), the Secretary may determine a maximum number of elections described in paragraph (1) by an individual that may be revoked by the individual.

(B) Minimum of one revocation option

In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

(3) Notification

The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive statements described in subsection (a) in an electronic format is made available, such as through the notices distributed under section 1395b–2 of this title, to individuals described in subsection (a).

(Aug. 14, 1935, ch. 531, title XVIII, § 1806, as added Pub. L. 105–33, title IV, § 4311(b)(1), Aug. 5, 1997, 111 Stat. 385; amended Pub. L. 114–10, title V, § 508(a), Apr. 16, 2015, 129 Stat. 169.)

Editorial Notes

AMENDMENTS

2015—Subsec. (c). Pub. L. 114–10 added subsec. (c).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 105–33, title IV, § 4311(b)(3), Aug. 5, 1997, 111 Stat. 386, provided that:

''(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act [42 U.S.C. 1395b–7(a)(1)], as added by paragraph (1), and the repeal made by paragraph (2) [amending section 1395b–5 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

''(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act [42 U.S.C. 1395b–7(a)(2), (b)], as so added, shall take effect not later than January 1, 1999.''

ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS

Pub. L. 114–10, title V, § 508(b), Apr. 16, 2015, 129 Stat. 169, provided that: ''To the extent to which the Secretary of Health and Human Services determines appropriate, the Secretary shall—

''(1) apply an option similar to the option described in subsection (c)(1) of section 1806 of the Social Security Act (42 U.S.C. 1395b–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications under title XVIII of such Act (42 U.S.C. 1395 et seq.); and

''(2) provide such Medicare Summary Notice and any such other statements and notifications on a more frequent basis than is otherwise required under such title.''

INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS

Pub. L. 108–173, title IX, § 925, Dec. 8, 2003, 117 Stat. 2396, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 8, 2003].''

§ 1395b–8. Chronic care improvement

(a) Implementation of chronic care improvement programs

(1) In general

The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this subchapter for targeted beneficiaries with one or more threshold conditions.

(2) Definitions

For purposes of this section:

(A) Chronic care improvement program

The term ''chronic care improvement program'' means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

(B) Chronic care improvement organization

The term ''chronic care improvement organization'' means an entity that has entered into an agreement under subsection (b)

or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

(C) Care management plan

The term ''care management plan'' means a plan established under subsection (d) for a participant in a chronic care improvement program.

(D) Threshold condition

The term ''threshold condition'' means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

(E) Targeted beneficiary

The term ''targeted beneficiary'' means, with respect to a chronic care improvement program, an individual who—

(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

(ii) has one or more threshold conditions covered under such program; and

(iii) has been identified under subsection (d)(1) as a potential participant in such program.

(3) Construction

Nothing in this section shall be construed as—

(A) expanding the amount, duration, or scope of benefits under this subchapter;

(B) providing an entitlement to participate in a chronic care improvement program under this section;

(C) providing for any hearing or appeal rights under section 1395ff, 1395*oo* of this title, or otherwise, with respect to a chronic care improvement program under this section; or

(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1395x(d) of this title).

(b) Developmental phase (Phase I)

(1) In general

In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after December 8, 2003.

(2) Agreement period

The period of an agreement under this subsection shall be for 3 years.

(3) Minimum participation

(A) In general

The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

(B) Medicare beneficiary defined

In this paragraph, the term ''medicare beneficiary'' means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

(4) Site selection

In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

(5) Independent evaluations of Phase I programs

The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes, including any cost savings to the program under this subchapter.

(c) Expanded implementation phase (Phase II)

(1) In general

With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

(2) Conditions for expansion of programs

The conditions specified in this paragraph are, with respect to a chronic care improve-

ment program conducted under subsection (b) for a threshold condition, that the program is expected to—

(A) improve the clinical quality of care;

(B) improve beneficiary satisfaction; and

(C) achieve targets for savings to the program under this subchapter specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

(3) Independent evaluations of Phase II programs

The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

(d) Identification and enrollment of prospective program participants

(1) Identification of prospective program participants

The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

(2) Initial contact by Secretary

The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

(A) A description of the advantages to the beneficiary in participating in a program.

(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

(C) Notification that participation in a program is voluntary.

(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

(3) Voluntary participation

A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

(e) Chronic care improvement programs

(1) In general

Each chronic care improvement program shall—

(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

(B) provide each targeted beneficiary participating in the program with such plan; and

(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

(2) Elements of care management plans

A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(3) Conduct of programs

In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

(4) Additional responsibilities

(A) Outcomes report

Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

(B) Additional requirements

Each such organization and program shall comply with such additional requirements as the Secretary may specify.

(5) Accreditation

The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

(f) Terms of agreements

(1) Terms and conditions

(A) In general

An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

(B) Clinical, quality improvement, and financial requirements

The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

(2) Manner of payment

Subject to paragraph (3)(B), the payment under an agreement under—

(A) subsection (b) shall be computed on a per-member per-month basis; or

(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

(3) Application of performance standards

(A) Specification of performance standards

Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this subchapter, against which the performance of the chronic care improvement organization under the agreement is measured.

(B) Adjustment of payment based on performance

(i) In general

Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

(ii) Financial risk for performance

In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this subchapter attributable to implementation of such agreement.

(4) Budget neutral payment condition

Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

(g) Funding

(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this subchapter (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.

(Aug. 14, 1935, ch. 531, title XVIII, § 1807, as added Pub. L. 108–173, title VII, § 721(a), Dec. 8, 2003, 117 Stat. 2341.)

Editorial Notes

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsecs. (a)(2)(E)(i) and (b)(3)(B), (4), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

Statutory Notes and Related Subsidiaries

DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES

Pub. L. 108–173, title VI, § 648, Dec. 8, 2003, 117 Stat. 2327, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary [of Health and Human Services] shall establish demonstration projects (in this section referred to as 'demonstration projects') under which the Secretary shall evaluate methods that improve the quality of care provided to individuals with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

''(2) INDIVIDUALS WITH CHRONIC CONDITIONS DEFINED.—In this section, the term 'individuals with chronic conditions' means an individual entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], and enrolled under part B of such title [42 U.S.C. 1395j et seq.], but who is not enrolled under part C of such title [42 U.S.C. 1395w–21 et seq.] who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

''(b) DESIGN OF PROJECTS.—

''(1) EVALUATION BEFORE IMPLEMENTATION OF PROJECT.—

''(A) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall

evaluate best practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices for a 1-year period and, based on such evaluation, shall design the demonstration project.

''(B) REQUIREMENT FOR ESTIMATE OF BUDGET NEUTRAL COSTS.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement the demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act [42 U.S.C. 1396 et seq.], that would otherwise be paid without regard to the demonstration projects for the period of the project.

''(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

''(c) VOLUNTARY PARTICIPATION.—Participation of providers of services and suppliers, and of individuals with chronic conditions, in the demonstration projects shall be voluntary.

''(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall conduct a demonstration project in at least one area that the Secretary determines has a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], and enrolled under part B of such title [42 U.S.C. 1395j et seq.], with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

''(e) EVALUATION AND REPORT.—

''(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

''(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

''(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

''(B) Evaluation of patient satisfaction under the demonstration projects.

''(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

''(f) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(g) AUTHORIZATION OF APPROPRIATIONS.—(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

''(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the deign [sic], implementation, and evaluation of the demonstration project.

''(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise have been made for the provision of personal care services.''

REPORTS

Pub. L. 108–173, title VII, §721(b), Dec. 8, 2003, 117 Stat. 2346, provided that: ''The Secretary [of Health and Human Services] shall submit to Congress reports on the operation of section 1807 of the Social Security Act [42 U.S.C. 1395b–8], as added by subsection (a), as follows:

''(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

''(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

''(B) Beneficiary and provider satisfaction.

''(C) Health outcomes.

''(D) Financial outcomes.

''(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

''(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

''(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

''(B) the design of the programs; and

''(C) the improvements in health outcomes and financial efficiencies that result from such implementation.''

CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY

Pub. L. 108–173, title VII, §723, Dec. 8, 2003, 117 Stat. 2348, provided that:

''(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

''(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

''(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

''(2) identify any new data needs and a methodology to address new data needs;

''(3) plan for the collection of such data in a data warehouse; and

''(4) develop a research agenda using such data.

''(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

''(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.''

§ 1395b–9. Provisions relating to administration

(a) Coordinated administration of medicare prescription drug and Medicare Advantage programs

(1) In general

There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

(2) Director

Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

(3) Duties

The duties described in this paragraph are the following:

(A) The administration of parts C and D.

(B) The provision of notice and information under section 1395b–2 of this title.

(C) Such other duties as the Secretary may specify.

(4) Deadline

The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.

(b) Employment of management staff

(1) In general

The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

(2) Eligibility

To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

(C) Actuarial sciences.

(D) Compliance with health plan contracts.

(E) Consumer education and decision making.

(F) Any other area specified by the Secretary that requires specialized management or other expertise.

(3) Rates of payment

(A) Performance-related pay

Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

(B) Limitation

In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5.

(c) Medicare Beneficiary Ombudsman

(1) In general

The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this subchapter.

(2) Duties

The Medicare Beneficiary Ombudsman shall—

(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

(iii) assistance to such individuals in presenting information under section 1395r(i)(4)(C) of this title (relating to income-related premium adjustment;[1] and

(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this subchapter as the Ombudsman determines appropriate.

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

(3) Working with health insurance counseling programs

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

(d) Pharmaceutical and technology ombudsman

(1) In general

Not later than 12 months after December 13, 2016, the Secretary shall provide for a pharmaceutical and technology ombudsman within the Centers for Medicare & Medicaid Services who shall receive and respond to complaints, grievances, and requests that—

[1] So in original. A closing parenthesis probably should precede the semicolon.

(A) are from entities that manufacture pharmaceutical, biotechnology, medical device, or diagnostic products that are covered or for which coverage is being sought under this subchapter; and

(B) are with respect to coverage, coding, or payment under this subchapter for such products.

(2) Application

The second sentence of subsection (c)(2) shall apply to the ombudsman under subparagraph (A) in the same manner as such sentence applies to the Medicare Beneficiary Ombudsman under subsection (c).

(e) Funding for implementation of beneficiary enrollment simplification

For purposes of carrying out the provisions of and the amendments made by section 120 of division CC of the Consolidated Appropriations Act, 2021, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in such proportion as the Secretary determines appropriate), to the Centers for Medicare & Medicaid Services Program Management Account, of $2,000,000 for each of fiscal years 2021 through 2030, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1808, as added and amended Pub. L. 108–173, title IX, §§ 900(a), (b), 923(a), Dec. 8, 2003, 117 Stat. 2369, 2393; Pub. L. 114–255, div. A, title IV, § 4010, Dec. 13, 2016, 130 Stat. 1185; Pub. L. 116–260, div. CC, title I, § 120(b), Dec. 27, 2020, 134 Stat. 2955.)

Editorial Notes

REFERENCES IN TEXT

Section 120 of division CC of the Consolidated Appropriations Act, 2021, referred to in subsec. (e), is section 120 of div. CC of Pub. L. 116–260, which amended this section and sections 1395i–2a, 1395p, 1395q, and 1395r of this title.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116–260 added subsec. (e).

2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).

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

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

Statutory Notes and Related Subsidiaries

DEADLINE FOR APPOINTMENT

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

§ 1395b–10. Addressing health care disparities

(a) Evaluating data collection approaches

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

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this subchapter.

(3) Improving Medicare program data on race, ethnicity, and gender.

(b) Reports to Congress

(1) Report on evaluation

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

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

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

(2) Reports on data analyses

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

(c) Implementing effective approaches

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

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

PART A—HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426–1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government

employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

(Aug. 14, 1935, ch. 531, title XVIII, § 1811, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 92–603, title II, § 201(a)(2), Oct. 30, 1972, 86 Stat. 1371; Pub. L. 95–292, § 4(a), June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title I, § 103(a)(2), June 9, 1980, 94 Stat. 444; Pub. L. 96–473, § 2(b), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96–499, title IX, § 930(a), Dec. 5, 1980, 94 Stat. 2631; Pub. L. 97–248, title I, § 122(a)(1), title II, § 278(b)(3), Sept. 3, 1982, 96 Stat. 356, 561; Pub. L. 99–272, title XIII, § 13205(b)(2)(C)(i), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100–360, title I, § 104(d)(1), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979.)

Editorial Notes

AMENDMENTS

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

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

1986—Pub. L. 99–272 substituted ''government employment'' for ''Federal employment'' in cls. (1) and (2).

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

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

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

Pub. L. 96–473 substituted ''are eligible for'' for ''are entitled to''.

Pub. L. 96–265 substituted ''not less than 24 months'' for ''not less than 24 consecutive months''.

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1989 AMENDMENT

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

EFFECTIVE DATE OF 1988 AMENDMENT

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

EFFECTIVE DATE OF 1986 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

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

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

EFFECTIVE DATE OF 1978 AMENDMENT

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

DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM

Pub. L. 115–271, title VI, § 6092, Oct. 24, 2018, 132 Stat. 3999, provided that:

''(a) IN GENERAL.—Not later than July 1, 2019, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

''(b) CONSULTATION.—In developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

''(1) medical professional organizations;

''(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

''(3) health care consumers or groups representing such consumers; and

''(4) other entities determined appropriate by the Secretary.

''(c) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection, the following:

''(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—

''(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;

''(B) ways to prevent, recognize, and treat opioid overdoses; and

''(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

''(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

''(A) the adverse effects of prolonged opioid use;

''(B) non-opioid, evidence-based, non-pharmacological pain management treatments;

''(C) monitoring programs for individuals who have been prescribed opioids; and

''(D) the prescribing of naloxone along with an initial opioid prescription.

''(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include use of the notification template described in paragraph (4)).

''(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

''(A) explains the risks and side effects associated with opioid use (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;

''(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;

''(C) encourages such individuals to talk to their health care providers about such alternatives;

''(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual's behalf, to acknowledge receipt of such notification template;

''(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and

''(F) includes any other information determined appropriate by the Secretary.

''(5) Best practices for such hospital to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

''(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;

''(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;

''(C) strategies to reduce long-term opioid prescriptions; and

''(D) methods to identify such practitioners who may be over-prescribing opioids.

''(6) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.''

ADVISORY COUNCIL TO STUDY COVERAGE OF DISABLED UNDER THIS SUBCHAPTER

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

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

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

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

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

''(2) the hospital (A) meets the requirements of paragraphs (5) and (7) of section 1861(e) of such Act [42 U.S.C. 1395x(e)(5), (7)], (B) is not primarily engaged in providing the services described in section 1961(j)(1)(A) of such Act [42 U.S.C. 1395x(j)(1)(A)], and (C) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) of such Act [42 U.S.C. 1395x(r)(1)], to inpatients (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

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

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

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

''(1) prior to July 1, 1966,

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

''(3) for more than—

''(A) 90 days in any spell of illness, but only if (i) prior to January 1, 1969, the hospital furnishing

such services entered into an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] and (ii) the hospital's plan for utilization review, as provided for in section 1861(k) of such Act [42 U.S.C. 1395x(k)], has, in accordance with section 1814 of such Act [42 U.S.C. 1395f], been applied to the services furnished such individual, or

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

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

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

''(d) For the purposes of this section—

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

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

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

§ 1395d. Scope of benefits

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

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

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

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

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

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

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

(A) consist of—

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

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

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

(b) Services not covered

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

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

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

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

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

(c) Inpatients of psychiatric hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Services taken into account

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

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

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

(2) The Secretary may provide—

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

(B) notwithstanding sections 1395f, 1395x(v), and 1395ww of this title, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

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

(g) "Spell of illness" defined

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

(Aug. 14, 1935, ch. 531, title XVIII, §1812, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 90–248, title I, §§129(c)(2), 137(a), 138(a), 143(b), 146(a), Jan. 2, 1968, 81 Stat. 847, 853, 854, 857, 859; Pub. L. 96–499, title IX, §§930(b)–(d), 931(a), Dec. 5, 1980, 94 Stat. 2631, 2633; Pub. L. 97–35, title XXI, §2121(a), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§122(b), 123, Sept. 3, 1982, 96 Stat. 356, 364; Pub. L. 97–448, title III, §309(b)(5), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 100–360, title I, §101, July 1, 1988, 102 Stat. 684; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title

VI, § 6003(g)(3)(B)(i), Dec. 19, 1989, 103 Stat. 2152; Pub. L. 101–508, title IV, § 4006(a), Nov. 5, 1990, 104 Stat. 1388–43; Pub. L. 103–432, title I, § 102(g)(1), Oct. 31, 1994, 108 Stat. 4404; Pub. L. 105–33, title IV, §§ 4201(c)(1), 4443(a), (b)(1), 4611(a), Aug. 5, 1997, 111 Stat. 373, 423, 472; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(k)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title V, § 512(a), title VII, § 736(c)(1), Dec. 8, 2003, 117 Stat. 2299, 2356.)

Editorial Notes

AMENDMENTS

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

Subsec. (a)(5). Pub. L. 108–173, § 512(a), added par. (5).

1999—Subsec. (b). Pub. L. 106–113 inserted ''during'' after ''100 visits'' in concluding provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(1) inpatient hospital services;

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

''(3) home health services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (d). Pub. L. 96–499, § 930(c), struck out subsec. (d) which authorized payment for post-hospital home health services furnished an individual only during the one year period described in section 1395x(n) of this title following his most recent hospital discharge which met the requirements of such section and only for the first 100 visits in such period.

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

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

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

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2003 AMENDMENT

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

EFFECTIVE DATE OF 1999 AMENDMENT

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

Pub. L. 105–33, title IV, § 4449, Aug. 5, 1997, 111 Stat. 424, provided that: ''Except as otherwise provided in this chapter [chapter 4 (§§ 4441–4449) of subtitle E of title IV of Pub. L. 105–33, amending this section and sections 1395f, 1395x, and 1395pp of this title and enacting provisions set out as notes under section 1395f and 1395x of this title], the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter [Aug. 5, 1997], regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.''

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

EFFECTIVE DATE OF 1994 AMENDMENT

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

EFFECTIVE DATE OF 1990 AMENDMENT

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

EFFECTIVE DATE OF 1989 AMENDMENT

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

EFFECTIVE DATE OF 1988 AMENDMENT

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

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

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

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

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

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

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

EFFECTIVE DATE OF 1983 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

Pub. L. 96–499, title IX, § 931(e), Dec. 5, 1980, 94 Stat. 2634, provided that: ''The amendments made by subsections (a) through (d) of this section [amending this

section and sections 1395f and 1395x of this title] shall become effective on April 1, 1981.''

EFFECTIVE DATE OF 1968 AMENDMENT

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

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

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

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

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

MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM

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

''(a) ESTABLISHMENT.—

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

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

''(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

''(b) INDEPENDENT EVALUATION AND REPORTS.—

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

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

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

PROTECTING HOME HEALTH BENEFITS

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

RURAL HOSPICE DEMONSTRATION PROJECT

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

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

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

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

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

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

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

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

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

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

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

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

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

Pub. L. 106–554, § 1(a)(6) [title III, § 323], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, required a study on the factors affecting the use of hospice benefits under the medicare program and a report on the study no later than 18 months after Dec. 21, 2000.

TRANSITION

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

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

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

''(A) 1998 is 1/6,

''(B) 1999 is 1/3,

''(C) 2000 is 1/2,

''(D) 2001 is 2/3, and

''(E) 2002 is 5/6.

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

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

''(i) For 1998, 1/7.

''(ii) For 1999, 2/7.

''(iii) For 2000, 3/7.

''(iv) For 2001, 4/7.

''(v) For 2002, 5/7.

''(vi) For 2003, 6/7.

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

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

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

§ 1395e. Deductibles and coinsurance

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Inpatient hospital deductible; application

(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied under section 1395ww(d)(3)(A) of this title for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

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

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

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

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

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

Editorial Notes

AMENDMENTS

1997—Pub. L. 105–33 substituted ''critical access'' for ''rural primary care'' wherever appearing.

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

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

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

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

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

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

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

1987—Subsec. (b)(1). Pub. L. 100–203, § 4002(f)(3), as added by Pub. L. 100–360, § 411(b)(1)(H)(ii), substituted ''Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied'' for ''applicable percentage increase (as defined in section 1395ww(b)(3)(B) of this title) which is applied''.

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

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

''(2) The Secretary shall, between July 1 and September 15 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) of this section in the case of any inpatient hospital services or post-hospital extended care services furnished during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $45 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two

multiplies of $4, to the next higher multiple of $4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1395cc of this title, to individuals who are entitled to hospital insurance benefits under section 426 of this title, plus the amount which would have been so paid but for subsection (a)(1) of this section.''

Subsec. (b)(2). Pub. L. 99–272 substituted ''September 15'' for ''October 1''.

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

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

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1989 AMENDMENT

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

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 102 of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

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

EFFECTIVE DATE OF 1986 AMENDMENT

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

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT

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

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

EFFECTIVE DATE OF 1968 AMENDMENT

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

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

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

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

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

''(a) IN GENERAL.—

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

''(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA [amending this section] (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act [42 U.S.C. 1395e(a)(2)] (relating to a deduction for blood).

''(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

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

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

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

''(C) the limitation of coverage of extended care services to post-hospital extended care services

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

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

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

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

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

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

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

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

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

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

''(B) if that individual begins a period of hospitalization (as defined in such section) during 1989 after the end of that spell of illness, the first period of hospitalization during 1989 that begins after that spell of illness shall be considered to be (for purposes of such section) the first period of hospitalization that begins during that year; and

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

PROMULGATION OF NEW DEDUCTIBLE

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

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

(a) Requirement of requests and certifications

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

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

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

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

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

[1] So in original.

for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be); such services are or were furnished while the individual was under the care of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary; or

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

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

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

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

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

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

(A)(i) in the first 90-day period—

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

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

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

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

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

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

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

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

(II) during the emergency period described in section 1320b–5(g)(1)(B) of this title, a hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth, as determined appropriate by the Secretary; and

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

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

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

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981 (or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020), and which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019 or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,,[1] and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician, nurse practitioner, clinical nurse specialist, or physician assistant who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved. For purposes of paragraph (2)(C), an individual shall be considered to be ''confined to his home'' if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered ''confined to his home'', the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be ''confined to his home''. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Amount paid to provider of services

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

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

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

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

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

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

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system. For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title.

(c) No payments to Federal providers of services

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

(d) Payments for emergency hospital services

(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital insurance benefits under section 426 of this title even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the con-

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

ditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1395n(b) of this title furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1395cc(a) of this title.

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 426 of this title for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

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

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

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

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

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

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

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

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

(A) such individual was physically present—

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

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

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

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

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

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 426 of this title may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimburse-

ment. The amount payable with respect to such services shall, subject to the provisions of section 1395e of this title, be equal to the amount which would be payable under subsection (d)(3).

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

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

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

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

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

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

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

(i) Payment for hospice care

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.3 percentage point.

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

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

(I) the excess (if any) of—

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

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

(II) 5 percentage points.

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

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

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

(ii) For purposes of subparagraph (A) for accounting years that end after September 30, 2016, and before October 1, 2030, the ''cap amount'' is the cap amount under this subparagraph for the preceding accounting year updated by the percentage update to payment rates for hospice care under paragraph (1)(C) for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year (including the application of any productivity or other adjustment under clause (iv) of that paragraph).

(iii) For accounting years that end after September 30, 2030, the cap amount shall be computed under clause (i) as if clause (ii) had never applied.

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

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

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

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

(5) QUALITY REPORTING.—

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

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

percentage points (or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points).

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

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

(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

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

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

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

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

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

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

(i) charges and payments;

(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under this part; and

(iii) with respect to each type of service included in hospice care—

(I) the number of days of hospice care attributable to the type of service;

(II) the cost of the type of service; and

(III) the amount of payment for the type of service;

(iv) charitable contributions and other revenue of the hospice program;

(v) the number of hospice visits;

(vi) the type of practitioner providing the visit; and

(vii) the length of the visit and other basic information with respect to the visit.

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

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

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

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

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

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

(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase

in the amount of payments made for those services under this subchapter. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this subchapter for services provided by that class of provider.

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

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

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

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

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

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

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

(*l*) Payment for inpatient critical access hospital services

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

(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1395i–4(c)(2)(E) of this title, the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v)[3] of section 1395ww(d)(1)(B) of this title.

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

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

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

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

(II) 20 percentage points.

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

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

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

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

(B) The percent described in this subparagraph is—

(i) for fiscal year 2015, 100.66 percent;

(ii) for fiscal year 2016, 100.33 percent; and

(iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.

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

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

(A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of

[3] See References in Text note below.

this title for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1395ww(n)(2) of this title;

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

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

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

(Aug. 14, 1935, ch. 531, title XVIII, §1814, as added Pub. L. 89–87, title I, §102(a), July 30, 1965, 79 Stat. 294; amended Pub. L. 90–248, title I, §§126(a), 129(c)(5), (6)(A), 143(c), Jan. 2, 1968, 81 Stat. 846, 848, 857; Pub. L. 92–603, title II, §§211(a), 226(c)(1), 227(b), 228(a), 233(a), 234(g)(1), 238(a), 247(a), 256(a), 278(a)(1)–(3), (b)(4), (17), 281(e), Oct. 30, 1972, 86 Stat. 1382, 1404, 1405, 1407, 1411, 1413, 1416, 1425, 1447, 1453, 1454, 1456; Pub. L. 93–233, §18(k)(1), (2), Dec. 31, 1973, 87 Stat. 970; Pub. L. 94–437, title IV, §401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 95–142, §23(a), (b), Oct. 25, 1977, 91 Stat. 1208; Pub. L. 95–292, §4(f), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§903(a), 930(e), (f), 931(b), 936(b), 941(a), (b), Dec. 5, 1980, 94 Stat. 2614, 2631, 2633, 2640, 2641; Pub. L. 97–35, title XXI, §§2121(b), 2122(a)(1), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§101(c)(1), 122(c)(1), (2), Sept. 3, 1982, 96 Stat. 335, 357, 358; Pub. L. 97–448, title III, §309(b)(7), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§601(d), 602(b), (c), Apr. 20, 1983, 97 Stat. 152, 163; Pub. L. 98–90, Aug. 29, 1983, 97 Stat. 606; Pub. L. 98–369, div. B, title III, §§2308(b)(2)(A), 2321(a), (f), 2335(a), 2336(a), (b), 2354(b)(1), (c)(1)(A), July 18, 1984, 98 Stat. 1074, 1084, 1085, 1090, 1091, 1100, 1102; Pub. L. 98–617, §§1(a), 3(a)(3), (b)(1), Nov. 8, 1984, 98 Stat. 3294, 3295; Pub. L. 99–272, title IX, §9123(b), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, §§4008(b)(1), 4024(a), 4062(d)(1), Dec. 22, 1987, 101 Stat. 1330–55, 1330–73, 1330–108; Pub. L. 100–360, title I, §104(d)(2), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title VI, §§6003(g)(3)(B)(ii), (iii), 6005(a), (b), 6028, Dec. 19, 1989, 103 Stat. 2152, 2160, 2161, 2168; Pub. L. 101–508, title IV, §§4006(b), 4008(i)(3), (m)(3)(A), Nov. 5, 1990, 104 Stat. 1388–43, 1388–51, 1388–53; Pub. L. 102–54, §13(q)(3)(A)(iii), (iv), (B)(iv), June 13, 1991, 105 Stat. 279; Pub. L. 103–66, title XIII, §13504, Aug. 10, 1993, 107 Stat. 579; Pub. L. 103–432, title I, §§102(a)(3), (d), 106(b)(1)(A), 110(d)(1), Oct. 31, 1994, 108 Stat. 4402, 4403, 4405, 4408; Pub. L. 105–33, title IV, §§4201(c)(1), (3), 4441, 4442(a), 4443(b)(2), 4448, 4603(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 422–424, 470, 475; Pub. L. 106–554, §1(a)(6) [title III, §§321(a), (e), 322(a)(1), title V, §507(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, 2763A–501, 2763A–532; Pub. L. 108–173, title IV, §§405(a)(1), (g)(2), 408(b), title V, §512(b), title VII, §736(a)(1), (2), (c)(2)(A), title IX, §946(b), Dec. 8, 2003, 117 Stat. 2266, 2269, 2270, 2299, 2354, 2356, 2425; Pub. L. 111–5, div. B, title IV, §4102(a)(2), (b)(2), (d)(1), Feb. 17, 2009, 123 Stat. 481, 483, 486; Pub. L. 111–148, title III, §§3004(c), 3108(a), 3132, 3401(g), title VI, §§6404(a)(1), 6405(b)(1), 6407(a)(1), title X, §§10319(f), 10604, 10605(a), Mar. 23, 2010, 124 Stat. 370, 418, 430, 484, 767–769, 949, 1006; Pub. L. 113–185, §3(c), (d), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title IV, §411(d), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title X, §§51002(a), 51006(a)(2), Feb. 9, 2018, 132 Stat. 292, 296; Pub. L. 116–136, div. A, title III, §§3706, 3708(a), Mar. 27, 2020, 134 Stat. 418; Pub. L. 116–260, div. CC, title IV, §§404, 407(b), Dec. 27, 2020, 134 Stat. 3002, 3008.)

[4] So in original. Probably should be ''1395ww(n)(3)(B)''.

Editorial Notes

REFERENCES IN TEXT

The amendments made by section 3708 of the CARES Act, referred to in subsec. (a), are the amendments made by section 3708 of Pub. L. 116–136, which amended this section and sections 1395n, 1395x, and 1395fff of this title.

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

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

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

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (*l*)(2), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–136, §3708(a)(4), in fourth sentence of concluding provisions, inserted ''or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,'' after ''January 1, 2019'' and '', nurse practitioner, clinical nurse specialist, or physician assistant'' after ''of the physician''.

Pub. L. 116–136, §3708(a)(3), in third sentence of concluding provisions, inserted '', nurse practitioner, clinical nurse specialist, or physician assistant'' after ''physician''.

Pub. L. 116–136, §3708(a)(2), in second sentence of concluding provisions, substituted ''With respect to the certification'' for ''With respect to the physician certification'' and ''which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who'' for ''which prohibit a physician who'' and inserted ''(or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020)'' after ''July 1, 1981''.

Subsec. (a)(2). Pub. L. 116–136, §3708(a)(1)(A), in introductory provisions, inserted '', a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is work-

ing in accordance with State law, who is'' after ''in the case of services described in subparagraph (C), a physician''.

Subsec. (a)(2)(C). Pub. L. 116–136, § 3708(a)(1)(B), inserted '', a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be)'' after ''reviewed by a physician'' and after ''care of a physician'' and substituted '', and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter'' for '', and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter''.

Subsec. (a)(7)(D)(i). Pub. L. 116–136, § 3706, designated existing provisions as subcl. (I), substituted ''subject to subclause (II), a hospice'' for ''a hospice'', and added subcl. (II).

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 116–260, § 404, substituted ''2030'' for ''2025''.

Subsec. (i)(5)(A)(i). Pub. L. 116–260, § 407(b), inserted ''(or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points)'' before period at end.

2018—Subsec. (a). Pub. L. 115–123, § 51002(a), inserted ''For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved.'' before ''For purposes of paragraph (2)(C),'' in concluding provisions.

Subsec. (a)(7)(A)(i)(I). Pub. L. 115–123, § 51006(a)(2), inserted ''or a physician assistant'' after ''a nurse practitioner''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2009—Subsec. (b). Pub. L. 111–5, § 4102(d)(1)(B), inserted at end of concluding provisions ''For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under sub-

section (b)(3)(B)(ix) or (n) of section 1395ww of this title.''

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1395i–4(a)(2) of this title (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

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

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

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

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

Subsec. (*l*)(2). Pub. L. 103–432, § 102(d), substituted ''January 1, 1996'' for ''January 1, 1993''.

1993—Subsec. (i)(1)(C)(ii). Pub. L. 103–66 substituted ''increased by—'' and subcls. (I) to (VI) for ''increased

by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) otherwise applicable to discharges occurring in the fiscal year.''

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(1) the lesser of—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (i)(1). Pub. L. 97–448 inserted ''made'' before ''for bereavement counseling''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (c). Pub. L. 96–499, §941(b), substituted ''subsection (h)'' for ''subsection (j)''.

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

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

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

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

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

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

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

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

Subsec. (a)(1). Pub. L. 92–603, §281(e), placed a 3-year time limitation on the time within which a written re-

quest for payment is filed, with provision for reduction of the limit to 1 year.

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

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

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

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

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

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

Subsec. (f). Pub. L. 92–603, § 211(a), designated existing provisions as par. (2), added pars. (1), (3), and (4), and in par. (2) as so redesignated inserted provisions covering individuals physically present at a place within Canada while traveling without unreasonable delay by the most direct route between Alaska and another State.

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

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

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

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

Subsec. (a)(2)(A) to (E). Pub. L. 90–248, § 126(a)(1), (2), struck out subpar. (A) which provided that there be a physician's certification of medical necessity for admissions to hospitals other than psychiatric or tuberculosis institutions, and redesignated subpars. (B) to (E) as (A) to (D), respectively.

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, § 3708(f), Mar. 27, 2020, 134 Stat. 421, provided that: ''The Secretary of Health and Human Services shall prescribe regulations to apply the amendments made by this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] to items and services furnished, which shall become effective no later than 6 months after the date of the enactment of this legislation [Mar. 27, 2020]. The Secretary shall promulgate an interim final rule if necessary, to comply with the required effective date.''

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title X, § 51006(b), Feb. 9, 2018, 132 Stat. 296, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2019.''

EFFECTIVE DATE OF 2010 AMENDMENT

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

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

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

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

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

EFFECTIVE DATE OF 2003 AMENDMENT

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

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

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

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

EFFECTIVE DATE OF 2000 AMENDMENT

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

Pub. L. 106–554, § 1(a)(6) [title III, § 322(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, § 1(a)(6) [title V, § 507(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–532, provided that: ''The

amendments made by paragraph (1) [amending this section and section 1395n of this title] shall apply to home health services furnished on or after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1997 AMENDMENT

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

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

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

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

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

EFFECTIVE DATE OF 1994 AMENDMENT

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

EFFECTIVE DATE OF 1990 AMENDMENT

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

EFFECTIVE DATE OF 1989 AMENDMENT

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

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

EFFECTIVE DATE OF 1988 AMENDMENT

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

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4008(b)(2), Dec. 22, 1987, 101 Stat. 1330–55, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].''

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

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

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

EFFECTIVE DATE OF 1984 AMENDMENT

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

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

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

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

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

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

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

EFFECTIVE DATE OF 1983 AMENDMENT

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

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub.

L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT

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

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

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

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

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

EFFECTIVE DATE OF 1978 AMENDMENT

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

EFFECTIVE DATE OF 1977 AMENDMENT

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

EFFECTIVE DATE OF 1973 AMENDMENT

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

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 211(d), Oct. 30, 1972, 86 Stat. 1384, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395u, 1395x, and 1395y of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1972.''

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE OF 1968 AMENDMENT

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

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

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

REVISION OF REGULATIONS REGARDING ACCESS TO HOME HEALTH SERVICES

Pub. L. 98–369, div. B, title III, § 2336(c)(2), July 18, 1984, 98 Stat. 1091, provided that: ''The Secretary shall

provide, not later than 90 days after the date of the enactment of this Act [July 18, 1984], for such revision of regulations as may be required to reflect the amendments made by subsection (b) [amending this section and section 1395n of this title].''

PROMULGATION OF REGULATIONS

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

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

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

APPLICATION TO MEDICAID

Pub. L. 116–136, div. A, title III, §3708(e), Mar. 27, 2020, 134 Stat. 421, provided that: ''The amendments made under this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] shall apply under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the same manner and to the same extent as such requirements apply under title XVIII of such Act [42 U.S.C. 1395 et seq.] or regulations promulgated thereunder.''

APPLICATION OF 2010 AMENDMENT

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

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

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

STUDY AND REPORT ON EFFECT OF 2000 AMENDMENT

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

''(1) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the effect of the amendment [amending this section and section 1395n of this title] on the cost of and access to home health services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

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

STUDY AND REPORT ON PHYSICIAN CERTIFICATION REQUIREMENT FOR HOSPICE BENEFITS

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

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

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

TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE

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

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

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

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

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

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

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

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §132], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that the Comptroller General of the United States would conduct a study, including cost factors, to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under subsec. (i) of this section for routine home care and other services included in hospice care, and provided the Comptroller General was to submit to Congress a report on the study together with any recommendations for legislation deemed appropriate not later than one year after Nov. 29, 1999.

STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE

Pub. L. 101–239, title VI, §6016, Dec. 19, 1989, 103 Stat. 2164, directed Secretary of Health and Human Services

to conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients, develop methods to compensate such programs for providing such high-cost care, and submit, not later than Apr. 1, 1991, a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study, including in the report any recommendations developed by the Secretary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES

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

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

[Pub. L. 100–647, title VIII, § 8402, Nov. 10, 1988, 102 Stat. 3798, provided that amendment of section 4008(c) of Pub. L. 100–203, set out above, by section 8402 of Pub. L. 100–647 is effective as of date of enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, which was approved Dec. 22, 1987.]

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

Pub. L. 98–369, div. B, title III, § 2308(a), July 18, 1984, 98 Stat. 1074, provided that: ''The Secretary of Health and Human Services shall issue regulations which require, for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], that providers of services calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h) [42 U.S.C. 1395*l*(h)]), and that payment under such title be based upon such separate determinations. Such regulations shall apply to cost reporting periods beginning on or after October 1, 1984.''

DETERMINATION OF NOMINAL CHARGES FOR APPLYING NOMINALITY TEST

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

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

Pub. L. 97–248, title I, § 122(j), formerly § 122(i), Sept. 3, 1982, 96 Stat. 363, as redesignated by Pub. L. 97–448, title III, § 309(a)(6), Jan. 12, 1983, 96 Stat. 2408, provided that the Secretary of Health and Human Services would conduct a study and, prior to January 1, 1986, report to the Congress on whether the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) were fair and equitable and promote the most efficient provision of hospice care.

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

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

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

Pub. L. 93–233, § 16, Dec. 31, 1973, 87 Stat. 967, provided that: ''In the administration of titles V, XVIII, and XIX of the Social Security Act [42 U.S.C. 701 et seq., 1395 et seq., 1396 et seq.], the amount payable under such title to any provider of services on account of services provided by such hospital, skilled nursing facility, or home health agency shall be determined (for any period with respect to which the amendments made by section 233 of Public Law 92–603 [this section and sections 706, 709, 1395*l*, and 1396b of this title] would, except for the provisions of this section, be applicable) in like manner as if the date contained in the first and second sentences of subsection (f) of such section 233 [set out as an Effective Date of 1972 Amendment note above] were December 31, 1973, rather than December 31, 1972.''

§ 1395g. Payments to providers of services

(a) Determination of amount

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

(b) Conditions

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

(c) Payments under assignment or power of attorney

No payment which may be made to a provider of services under this subchapter for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

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

Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments (or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program under subsection (e)(3), including such program as expanded pursuant to subsection (f), at a rate of 4 percent).

(e) Periodic interim payments

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

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

(B) In the case of a hospital that—

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

(ii) requests payment on such basis,

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

(C) In the case of a hospital that—

(i) is located in a rural area,

(ii) has 100 or fewer beds, and

(iii) requests payment on such basis,

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

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

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

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

(C) extended care services;

(D) hospice care; and

(E) inpatient critical access hospital services;

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

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

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

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

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

(f) Expansion of accelerated payment program during COVID–19 public health emergency

(1) During the emergency period described in section 1320b–5(g)(1)(B) of this title, the Secretary shall expand the program under subsection (e)(3) pursuant to paragraph (2).

(2) In expanding the program under subsection (e)(3), the following shall apply:

(A)(i) In addition to the hospitals described in subsection (e)(3), the following hospitals shall be eligible to participate in the program:

(I) Hospitals described in clause (iii) of section 1395ww(d)(1)(B) of this title.

(II) Hospitals described in clause (v) of such section.

(III) Critical access hospitals (as defined in section 1395x(mm)(1) of this title).

(ii) Subject to appropriate safeguards against fraud, waste, and abuse, upon a request of a hospital described in clause (i), the Secretary shall (or, with respect to requests submitted to the Secretary after April 26, 2020, may) provide accelerated payments under the program to such hospital.

(B) Upon the request of the hospital, the Secretary may do any of the following:

(i) Make accelerated payments on a periodic or lump sum basis.

(ii) Increase the amount of payment that would otherwise be made to hospitals under the program up to 100 percent (or, in the case of critical access hospitals, up to 125 percent).

(iii) Extend the period that accelerated payments cover so that it covers up to a 6-month period.

(C) In the case of a payment made under the terms of the program under subsection (e)(3), including such program as expanded pursuant to this subsection, on or after March 27, 2020, and so made during the emergency period described in section 1320b–5(g)(1)(B) of this title, upon request of a hospital, the Secretary shall—

(i) provide 1 year before payments for items and services furnished by the hospital are offset to recoup payments under such program;

(ii) provide that any such offset be an amount equal to—

(I) during the first 11 months in which any such offsets are made with respect to payment for items and services furnished by the hospital, 25 percent of the amount of such payment for such items and services; and

(II) during the succeeding 6 months, 50 percent of the amount of such payment for such items and services; and

(iii) allow 29 months from the date of the first payment under such program to such provider before requiring that the outstanding balance be paid in full.

(3) Nothing in this subsection shall preclude the Secretary from carrying out the provisions described in clauses (i), (ii), and (iii) of paragraph (2)(B) and clauses (i) and (ii) of paragraph (2)(C) under the program under subsection (e)(3) after the period for which this subsection applies.

(4) Notwithstanding any other provision of law, the Secretary may implement the provisions of this subsection by program instruction or otherwise.

(Aug. 14, 1935, ch. 531, title XVIII, § 1815, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 94–182, title I, § 112(a)(2), Dec. 31, 1975, 89 Stat. 1055; Pub. L. 95–142, § 2(a)(2), Oct. 25, 1977, 91 Stat. 1175; Pub. L. 96–473, § 6(i), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 97–248, title I, §§ 117(a)(1), 148(b), Sept. 3, 1982, 96 Stat. 354, 394; Pub. L. 99–509, title IX, § 9311(a)(1), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 101–239, title VI, § 6021(a), Dec. 19, 1989, 103 Stat. 2166; Pub. L. 105–33, title IV, § 4603(b), Aug. 5, 1997, 111 Stat. 470; Pub. L. 108–173, title IV, § 405(c)(1), title VII, § 736(a)(3), Dec. 8, 2003, 117 Stat. 2266, 2354; Pub. L. 108–271, § 8(b), July 7, 2004, 118 Stat. 814; Pub. L. 112–40, title II, § 261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 116–136, div. A, title III, § 3719, Mar. 27, 2020, 134 Stat. 426; Pub. L. 116–159, div. C, title V, § 2501(a)(1)(A), (B), (b)(1)(A), Oct. 1, 2020, 134 Stat. 733–735.)

Editorial Notes

AMENDMENTS

2020—Subsec. (d). Pub. L. 116–159, §2501(b)(1)(A), inserted before period at end ''(or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program under subsection (e)(3), including such program as expanded pursuant to subsection (f), at a rate of 4 percent)''.

Subsec. (e)(3). Pub. L. 116–136, §3719(1), substituted ''Subject to subsection (f), in the case'' for ''In the case''.

Subsec. (f). Pub. L. 116–136, §3719(2), added subsec. (f).

Subsec. (f)(2)(A)(ii). Pub. L. 116–159, §2501(a)(1)(B), which directed insertion of ''(or, with respect to requests submitted to the Secretary after April 26, 2020, may)'' after ''shall.'', was executed by making the insertion after ''shall'' to reflect the probable intent of Congress.

Subsec. (f)(2)(C). Pub. L. 116–159, §2501(a)(1)(A), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''Upon the request of the hospital, the Secretary shall do the following:

''(i) Provide up to 120 days before claims are offset to recoup the accelerated payment.

''(ii) Allow not less than 12 months from the date of the first accelerated payment before requiring that the outstanding balance be paid in full.''

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

2004—Subsec. (a). Pub. L. 108–271 substituted ''Government Accountability Office'' for ''General Accounting Office''.

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

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

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

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

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

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

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

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

1980—Subsec. (c). Pub. L. 96–473 substituted ''for or in connection with'' for ''for on in connection with''.

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

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

EFFECTIVE DATE OF 2003 AMENDMENT

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1989 AMENDMENT

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

EFFECTIVE DATE OF 1986 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

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

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, §2(a)(4), Oct. 25, 1977, 91 Stat. 1176, provided that: ''The amendments made by this subsection [amending this section and sections 1395u and 1396a of this title] shall apply with respect to care and services furnished on or after the date of the enactment of this Act [Oct. 25, 1977].''

EFFECTIVE DATE OF 1975 AMENDMENT

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

APPLICATION TO OTHER PART A PROVIDERS

Pub. L. 116–159, div. C, title V, §2501(a)(1)(C), Oct. 1, 2020, 134 Stat. 734, provided that:

''(i) IN GENERAL.—In the case of a payment made under the terms of an applicable program (as defined in clause (ii)), on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and so made during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), upon request of an applicable provider (as defined in clause (iii)), the provisions of section 1815(f)(2)(C) of such Act (42 U.S.C. 1395g(f)(2)(C)), as amended by subparagraph (A), shall apply with respect to such payment in the same manner as such provisions apply with respect to a payment made under the terms of the program under subsection (e)(3) of section 1815 of such Act (42 U.S.C. 1395g), including such program as expanded pursuant to subsection (f) of such section, on or after the date of the enactment of the CARES Act (Public Law 116–136) and so made during such emergency period.

''(ii) APPLICABLE PROGRAM DEFINED.—In this clause, the term 'applicable program' means—

''(I) the programs under sections 413.64(g), 412.541(f), 412.632(e), 412.116(f), 413.350(d), or 418.307 of title 42, Code of Federal Regulations (or any successor regulations); and

''(II) any other comparable program under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], as determined by the Secretary.

''(iii) APPLICABLE PROVIDER.—In this clause, the term 'applicable provider' means a provider of services that is eligible for payment under an applicable program.''

Pub. L. 116–159, div. C, title V, § 2501(b)(1)(B), Oct. 1, 2020, 134 Stat. 736, provided that: ''In the case of a determination under section 1815(d) of the Social Security Act (42 U.S.C. 1395g(d)) with respect to a payment made on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) under an applicable program (as defined in subsection (a)(1)(C)(ii)), the amendment made by subparagraph (A) [amending this section] shall apply with respect to such determination in the same manner as such amendment applies with respect to a payment made on or after the date of the enactment of the CARES Act (Public Law 116–136) and during such emergency period under the program under subsection (e)(3) of section 1815 of such Act (42 U.S.C. 1395g), including such program as expanded pursuant to subsection (f) of such section.''

PUBLICATION OF DATA

Pub. L. 116–159, div. C, title V, § 2501(c), Oct. 1, 2020, 134 Stat. 736, provided that:

''(1) DATA DURING COVID–19 EMERGENCY.—

''(A) INITIAL PUBLICATION.—Not later than 2 weeks after the date of the enactment of this section [Oct. 1, 2020], the Secretary shall post on the public website of the Centers for Medicare & Medicaid Services data that includes the following information with respect to specified payments (as defined in paragraph (3)(E)) made as of such date and for which data is available:

''(i) The total amount of such payments made under each applicable payment program (as defined in paragraph (3)(A)), including a specification of the percentage of such payments so made from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the percentage of such payments so made from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) under each such program.

''(ii) The amount of specified payments made under each such program by type of provider of services or supplier receiving such payments.

''(iii) The Centers for Medicare & Medicaid Services certification number or other appropriate number of, and the amount of such payments received by, each provider of services and supplier receiving such payments.

''(B) INTERIM PUBLICATION.—Every 2 weeks thereafter during the emergency period, if any specified payments are made that were not included in a preceding publication of data under this paragraph, the Secretary shall post on the website described in subparagraph (A) data containing the information described in clauses (i), (ii), and (iii) of such subparagraph with respect to such specified payments.

''(2) ADDITIONAL PUBLICATIONS.—Not later than 15 months after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020], and every 6 months thereafter until all specified payments have been recouped or repaid, the Secretary shall post on the website described in paragraph (1)(A) data that includes the following:

''(A) The total amount of all specified payments not recouped or repaid under each applicable payment program.

''(B) The amount of payments made under each such program and not recouped or repaid by type of provider of services or supplier.

''(C) The total amount of specified payments that have been recouped or repaid under each such program, including a specification of the percentage of such payments so recouped or repaid that have been deposited into the Federal Hospital Insurance Trust Fund and the percentage of such payments so recouped or repaid that have been deposited into the Federal Supplementary Insurance Trust Fund under each such program.

''(D) The dollar amount of interest that has been collected with respect to all specified payments under each such program.

''(3) DEFINITIONS.—In this subsection:

''(A) APPLICABLE PAYMENT PROGRAM.—The term 'applicable payment program' means—

''(i) the program under subsection (e)(3) of section 1815 of the Social Security Act (42 U.S.C. 1395g), including such program as expanded under subsection (f) of such section;

''(ii) an applicable program (as defined in subsection (a)(1)(C)(ii) of this section [set out as a note above]); and

''(iii) the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation).

''(B) EMERGENCY PERIOD.—The term 'emergency period' means the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)).

''(C) PROVIDER OF SERVICES AND SUPPLIER.—The terms 'provider of services' and 'supplier' have the meaning given such terms in subsections (u) and (d), respectively, of section 1861 of such Act (42 U.S.C. 1395x).

''(D) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(E) SPECIFIED PAYMENTS.—The term 'specified payments' means payments made under an applicable payment program on or after the date of the enactment of the CARES Act (Public Law 116–136) during the emergency period.''

DEVELOPMENT OF ALTERNATIVE TIMING METHODS OF PERIODIC INTERIM PAYMENTS

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

TRANSITION

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

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

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

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

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

DELAY IN PERIODIC INTERIM PAYMENTS

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

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

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

Pub. L. 96–499, title IX, § 959, Dec. 5, 1980, 94 Stat. 2650, provided for deferral of interim payments to be made

during last twenty-one days of fiscal year 1981 until fiscal year 1982, prior to repeal by Pub. L. 97–35, title XXI, § 2155, Aug. 13, 1981, 95 Stat. 802.

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

(a) In general

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

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

(c) Prompt payment of claims

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

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

(i) which are clean claims, and

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

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

(B) In this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

(d) to (i). Repealed. Pub. L. 108–173, title IX, § 911(b)(5), Dec. 8, 2003, 117 Stat. 2383

(j) Denial of claim; notification and reconsideration

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

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

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

(k) Annual reporting requirement on erroneous payment recovery

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

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

(Aug. 14, 1935, ch. 531, title XVIII, § 1816, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 92–603, title II, § 243(b), Oct. 30, 1972, 86 Stat. 1422; Pub. L. 95–142, § 14(a), Oct. 25, 1977, 91 Stat. 1198; Pub. L. 96–499, title IX, § 930(*o*), Dec. 5, 1980, 94 Stat. 2632; Pub. L. 97–248, title I, § 122(c)(3), Sept. 3, 1982, 96 Stat. 359; Pub. L. 98–369, div. B, title III, § 2326(b), (c)(1), (d)(1), July 18, 1984, 98 Stat. 1087; Pub. L. 99–509, title IX, §§ 9311(b), 9352(a)(2), Oct. 21, 1986, 100 Stat. 1997, 2044; Pub. L. 100–203, title IV, §§ 4031(a)(1), 4032(a), (b), 4035(a)(1), 4085(d)(1), Dec. 22, 1987, 101 Stat. 1330–75 to 1330–78, 1330–130; Pub.

L. 100–360, title II, § 203(f), title IV, § 411(e)(1)(B), July 1, 1988, 102 Stat. 725, 775; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6003(g)(3)(D)(vi), 6202(d)(1), Dec. 19, 1989, 103 Stat. 2153, 2234; Pub. L. 101–508, title IV, § 4005(c)(1)(A), Nov. 5, 1990, 104 Stat. 1388–41; Pub. L. 103–66, title XIII, § 13568(a), (b), Aug. 10, 1993, 107 Stat. 608; Pub. L. 103–432, title I, §§ 110(d)(2), 151(b)(1)(A), (2)(A), Oct. 31, 1994, 108 Stat. 4408, 4433, 4434; Pub. L. 104–191, title II, § 202(b)(1), Aug. 21, 1996, 110 Stat. 1998; Pub. L. 105–33, title IV, § 4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, § 736(a)(4), title IX, § 911(b), Dec. 8, 2003, 117 Stat. 2355, 2383; Pub. L. 109–171, title V, § 5202(a)(1), Feb. 8, 2006, 120 Stat. 47.)

Editorial Notes

AMENDMENTS

2006—Subsec. (c)(3)(B)(ii). Pub. L. 109–171 substituted ''28 days'' for ''26 days''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (f)(2)(A)(ii). Pub. L. 103–432, § 110(d)(2), substituted ''such agency's'' for ''such agency''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2006 AMENDMENT

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

EFFECTIVE DATE OF 2003 AMENDMENT

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 151(b)(4), Oct. 31, 1994, 108 Stat. 4435, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to contracts with fiscal intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for contract years beginning with 1995.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13568(c), Aug. 10, 1993, 107 Stat. 608, provided that: ''The amendments made by this section [amending this section and section 1395u of this title] shall apply to claims received on or after October 1, 1993.''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6202(d)(3), Dec. 19, 1989, 103 Stat. 2234, provided that: ''The amendments made by this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 19, 1989].''

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(f) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(e)(1)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4031(a)(3)(A), Dec. 22, 1987, 101 Stat. 1330–76, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to claims received on or after July 1, 1988.''

Pub. L. 100–203, title IV, § 4032(c)(1), Dec. 22, 1987, 101 Stat. 1330–77, as amended by Pub. L. 100–360, title IV, § 411(e)(1)(C), July 1, 1988, 102 Stat. 775, provided that:

''(A) The amendment made by subsection (a) [amending this section] shall apply with respect to claims received on or after January 1, 1988.

''(B) The amendment made by subsection (b) [amending this section] shall apply with respect to reconsiderations requested on or after October 1, 1988.''

Pub. L. 100–203, title IV, § 4035(a)(3), Dec. 22, 1987, 101 Stat. 1330–78, provided that: ''The amendments made by this section [amending this section and sections 1395u and 1395hh of this title] shall take effect on the date of the enactment of this Act [Dec. 22, 1987] and shall apply to budgets for fiscal years beginning with fiscal year 1989.''

Pub. L. 100–203, title IV, § 4085(d)(2), Dec. 22, 1987, 101 Stat. 1330–131, provided that:

''(A) The amendment made by paragraph (1) [amending this section] shall apply to claims received on or after the date of enactment of this Act [Dec. 22, 1987].

''(B) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42 U.S.C. 1395h], and regulations, to such extent as may be necessary to implement the amendment made by paragraph (1).''

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9311(d), Oct. 21, 1986, 100 Stat. 1999, provided that:

''(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section and section 1395u of this title] shall apply to claims received on or after November 1, 1986.

''(2) Sections 1816(c)(2)(C)) [sic] and 1842(c)(2)(C) of the Social Security Act [42 U.S.C. 1395h(c)(2)(C), 1395u(c)(2)(C)], as added by such amendments, shall apply to claims received on or after April 1, 1987.

''(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis.''

Amendment by section 9352(a)(2) of Pub. L. 99–509 to be implemented by Secretary of Health and Human Services not later than 6 months after Oct. 21, 1986, see section 9352(c)(1) of Pub. L. 99–509, set out as a note under section 1320c–2 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2326(d)(3), July 18, 1984, 98 Stat. 1088, provided that: ''The amendments made by this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed after September 30, 1984.''

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–499 effective Dec. 5, 1980, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, § 14(c), (d), Oct. 25, 1977, 91 Stat. 1200, provided that:

''(c) The amendment made by paragraphs (2) and (3) of subsection (a) [amending this section] to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act [42 U.S.C. 1395h(f)] shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

''(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) [amending this section] shall apply to agreements entered into or renewed on or after the date of enactment of this Act [Oct. 25, 1977].''

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to cost reports of providers of services for accounting periods ending on or after June 30, 1973, see section 243(c) of Pub. L. 92–603, set out as an Effective Date note under section 1395*oo* of this title.

ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS

Pub. L. 100–360, title IV, § 427, July 1, 1988, 102 Stat. 814, which provided that the Administrator of the Health Care Financing Administration was to establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials, was repealed by Pub. L. 101–234, title III, § 301(a), Dec. 13, 1989, 103 Stat. 1985.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4031(a) OF PUB. L. 100–203

Pub. L. 100–203, title IV, § 4031(a)(3)(B), Dec. 22, 1987, 101 Stat. 1330–76, provided that: ''The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this subsection [amending this section and section 1395u of this title] on a timely basis.''

PROHIBITION OF POLICIES OTHER THAN AS PROVIDED BY SECTION 4031 OF PUB. L. 100–203 INTENDED TO SLOW DOWN MEDICARE PAYMENTS; BUDGET CONSIDERATIONS

Pub. L. 100–203, title IV, § 4031(b), (c), Dec. 22, 1987, 101 Stat. 1330–76, provided that, notwithstanding any other provision of law, the Secretary of Health and Human Services was not authorized to issue, after Dec. 22, 1987, and before Oct. 1, 1990, any final regulation, instruction, or other policy change which was primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under this subchapter, and that section 4031 of Pub. L. 100–203, amending this section and section 1395u of this title and enacting provisions set out as notes under this section, was a necessary (but secondary) result of a significant policy change.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4032(a), (b) OF PUB. L. 100–203

Pub. L. 100–203, title IV, § 4032(c)(2), Dec. 22, 1987, 101 Stat. 1330–77, provided that: ''The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42 U.S.C. 1395h] and contracts under section 1842 of the Social Security Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the amendments made by subsections (a) and (b) [amending this section] on a timely basis.''

REPLACEMENT OF AGENCY, ORGANIZATION, OR CARRIER PROCESSING MEDICARE CLAIMS; NUMBER OF AGREEMENTS AND CONTRACTS AUTHORIZED FOR FISCAL YEARS 1985 THROUGH 1993

Pub. L. 98–369, div. B, title III, § 2326(a), July 18, 1984, 98 Stat. 1087, as amended by Pub. L. 98–617, § 3(a)(2), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, § 9321(b), Oct. 21, 1986, 100 Stat. 2016; Pub. L. 101–239, title VI, § 6215(a), Dec. 19, 1989, 103 Stat. 2252; Pub. L. 103–432, title I, § 159(a), Oct. 31, 1994, 108 Stat. 4443, provided that: ''During each fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1993), the Secretary of Health and Human Services may enter into not more than two agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h], and not more than two contracts under section 1842 of such Act [42 U.S.C. 1395u], on the basis of competitive bidding, without regard to the nominating process under section 1816(a) of such Act or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act during the term of the agreement. Such procedure may be used only for the purpose of replacing an agency or organization or carrier which over a 2-year period of time has been in the lowest 20th percentile of agencies and organizations or carriers having agreements or contracts under the respective section, as measured by the Secretary's cost and performance criteria. In addition, beginning with fiscal year 1990 and any subsequent fiscal

year the Secretary may enter into such additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract. Any agency or organization or carrier selected on the basis of competitive bidding must perform all of the duties listed in section 1816(a) of such Act, or the duties listed in paragraphs (1) through (4) of section 1842(a) of such Act, as the case may be, and must be a health insuring organization (as determined by the Secretary).''

[Pub. L. 103–432, title I, §159(b), Oct. 31, 1994, 108 Stat. 4443, provided that: ''The amendment made by subsection (a) [amending section 2326(a) of Pub. L. 98–369, set out above] shall apply beginning with fiscal year 1994.'']

[Pub. L. 101–239, title VI, §6215(b), Dec. 19, 1989, 103 Stat. 2252, provided that: ''The amendments made by subsection (a) [amending section 2326(a) of Pub. L. 98–369, set out above] shall apply beginning with fiscal year 1990.'']

AUDIT AND MEDICAL CLAIMS REVIEW

Pub. L. 97–248, title I, §118, Sept. 3, 1982, 96 Stat. 355, as amended by Pub. L. 99–272, title IX, §9216(a), Apr. 7, 1986, 100 Stat. 180, provided that, in addition to any funds otherwise provided for payments to intermediaries and carriers under agreements entered into under this section and section 1395u of this title, there were transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Fund an additional $45,000,000 for each of fiscal years 1983, 1984, and 1985, and $105,000,000 for each of fiscal years 1986, 1987, and 1988 for payments to such intermediaries and carriers under such agreements to be used exclusively for purposes of carrying out provider cost audits, of reviewing medical necessity, and of recovering third-party liability payments.

DEVELOPMENTAL DATE FOR STANDARDS, CRITERIA, AND PROCEDURES PURSUANT TO SUBSEC. (f) OF THIS SECTION

Pub. L. 95–142, §14(b), Oct. 15, 1977, 91 Stat. 1200, directed the Secretary of Health, Education, and Welfare to develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act [42 U.S.C. 1395h(f)] (as added by subsection (a)(5)) not later than Oct. 1, 1978.

§ 1395i. Federal Hospital Insurance Trust Fund

(a) Creation; deposits; transfers from Treasury

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Federal Hospital Insurance Trust Fund'' (hereinafter in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1986 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of records of wages established and maintained by the Commissioner of Social Security in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1986 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of records of self-employment established and maintained by the Commissioner of Social Security in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) Board of Trustees; composition; meetings; duties

With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the ''Board of Trustees'') composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the ''Managing Trustee''). The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the pre-

ceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) Investment of Trust Fund by Managing Trustee

It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Authority of Managing Trustee to sell obligations

Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) Interest on and proceeds from sale or redemption of obligations

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) Payment of estimated taxes

(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1986 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1986, and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) Transfers from other Funds

There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1395gg(b) of this title. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the

[1] So in original. See 2003 Amendment note below.

Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1395gg(b) of this title.

(h) Payments from Trust Fund amounts certified by Secretary

The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 401(g)(1) of this title.

(i) Payment of travel expenses for travel within United States; reconsideration interviews and proceedings before administrative law judges

There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 410(i) of this title) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this subchapter. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(j) Loans from other Funds; interest; repayment; report to Congress

(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may, subject to paragraph (5), borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from such Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Hospital Insurance Trust Fund, the Managing Trustee determines that the Hospital Insurance Trust Fund ratio exceeds 15 percent, he shall transfer from such Trust Fund to the lending trust fund an amount that—

(I) together with any amounts transferred to another lending trust fund under this paragraph for such year, will reduce the Hospital Insurance Trust Fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term ''Hospital Insurance Trust Fund ratio'' means, with respect to any calendar year, the ratio of—

(I) the balance in the Federal Hospital Insurance Trust Fund, as of the last day of such calendar year; to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Hospital Insurance Trust Fund during the calendar year following such calendar year (other than payments of interest on, and repayments of, loans from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under paragraph (1)), and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from the Railroad Retirement Account.

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987 and before January 1, 1990, the Managing Trustee shall transfer each month from the Federal Hospital Insurance Trust Fund to any Trust Fund that is owed any amount by the Federal Hospital Insurance Trust Fund on a loan made under paragraph (1), an amount not less than an amount equal to (I) the amount owed to such Trust Fund by the Federal Hospital Insurance

Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be loaned by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund under paragraph (1) during any month if the OASDI trust fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term ''OASDI trust fund ratio'' means, with respect to any month, the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Trust Fund from the Federal Hospital Insurance Trust Fund under section 401(*l*) of this title, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the month for which such ratio is to be determined for all purposes authorized by section 401 of this title (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 401(*l*) of this title), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account.

(k) Health Care Fraud and Abuse Control Account

(1) Establishment

There is hereby established in the Trust Fund an expenditure account to be known as the ''Health Care Fraud and Abuse Control Account'' (in this subsection referred to as the ''Account'').

(2) Appropriated amounts to Trust Fund

(A) In general

There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996, and subchapter XI; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

(B) Authorization to accept gifts

The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

(C) Transfer of amounts

The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 24(a) of title 18).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under this subchapter and subchapters XI and XIX, and chapter 38 of title 31 (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31 (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(D) Application

Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.] for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

(3) Appropriated amounts to Account for fraud and abuse control program, etc.

(A) Departments of Health and Human Services and Justice

(i) In general

There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended, in an amount not to exceed—

(I) for fiscal year 1997, $104,000,000;

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent;

(III) for each of fiscal years 2004, 2005, and 2006, the limit for fiscal year 2003; and

(IV) for each fiscal year after fiscal year 2006, the limit under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(ii) Medicare and medicaid activities

For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the programs under this subchapter and subchapter XIX—

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000;

(VII) for each of fiscal years 2003, 2004, 2005, and 2006, not less than $150,000,000 and not more than $160,000,000;

(VIII) for fiscal year 2007, not less than $160,000,000, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and

(IX) for each fiscal year after fiscal year 2007, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(B) Federal Bureau of Investigation

There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended—

(i) for fiscal year 1997, $47,000,000;

(ii) for fiscal year 1998, $56,000,000;

(iii) for fiscal year 1999, $66,000,000;

(iv) for fiscal year 2000, $76,000,000;

(v) for fiscal year 2001, $88,000,000;

(vi) for fiscal year 2002, $101,000,000;

(vii) for each of fiscal years 2003, 2004, 2005, and 2006, $114,000,000; and

(viii) for each fiscal year after fiscal year 2006, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(C) Use of funds

The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1320a–7c(a) of this title, including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of subchapter XI.

(4) Appropriated amounts to Account for Medicare Integrity Program

(A) In general

There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary for activities described in paragraph (3)(C) and to carry out the Medicare Integrity Program under section 1395ddd of this title, subject to subparagraphs (B), (C), and (D) and to be available without further appropriation until expended.

(B) Amounts specified

Subject to subparagraph (C), the amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(C) Adjustments

The amount appropriated under subparagraph (A) for a fiscal year is increased as follows:

(i) For fiscal year 2006, $100,000,000.

(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(D) Expansion of the Medicare-Medicaid Data Match Program

The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1395ddd(b)(6) of this title for the respective fiscal year:

(i) $12,000,000 for fiscal year 2006.
(ii) $24,000,000 for fiscal year 2007.
(iii) $36,000,000 for fiscal year 2008.
(iv) $48,000,000 for fiscal year 2009.
(v) $60,000,000 for fiscal year 2010 and each fiscal year thereafter.

(5) Annual report

Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

(6) GAO report

Not later than June 1, 1998, and January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

(A) identifies—

(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

(ii) the amounts appropriated from the Trust Fund for such fiscal years under paragraph (3) and the justification for the expenditure of such amounts;

(B) identifies any expenditures from the Trust Fund with respect to activities not involving the program under this subchapter;

(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.

(7) Additional funding

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(8) Additional funding

(A) In general

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3)(C) and (4)(A) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated to such Account from such Trust Fund the following additional amounts:

(i) For fiscal year 2011, $95,000,000.
(ii) For fiscal year 2012, $55,000,000.
(iii) For each of fiscal years 2013 and 2014, $30,000,000.
(iv) For each of fiscal years 2015 and 2016, $20,000,000.

(B) Allocation

The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1817, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 299; amended Pub. L. 90–248, title I, § 169(a), Jan. 2, 1968, 81 Stat. 875; Pub. L. 92–603, title I, § 132(d), Oct. 30, 1972, 86 Stat. 1361; Pub. L. 95–292, § 5, June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title III, § 310(c), June 9, 1980, 94 Stat. 460; Pub. L. 97–123, § 1(b), Dec. 29, 1981, 95 Stat. 1659; Pub. L. 98–21, title I, §§ 141(b), 142(b)(1), (2)(A), (3), (4), 154(b), title III, § 341(b), Apr. 20, 1983, 97 Stat. 98, 100, 101, 107, 135; Pub. L. 98–369, div. B, title III, §§ 2337(a), 2354(b)(2), title VI, § 2663(j)(2)(F)(i), July 18, 1984, 98 Stat. 1091, 1100, 1170; Pub. L. 99–272, title IX, § 9213(b), Apr. 7, 1986, 100 Stat. 180; Pub. L. 99–514, § 2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–360, title II, § 212(c)(3), July 1, 1988, 102 Stat. 741; Pub. L. 100–647, title VIII, § 8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101–234, title II, § 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–508, title V, § 5106(c), Nov. 5, 1990, 104 Stat. 1388–268; Pub. L. 103–296, title I, § 108(c)(1), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 104–191, title II, § 201(b), Aug. 21, 1996, 110 Stat. 1993; Pub. L. 105–33, title IV, § 4318, Aug. 5, 1997, 111 Stat. 392; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(j)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title VII, § 736(a)(5), (6), title VIII, § 801(d)(1), title IX, § 900(e)(1)(D), Dec. 8, 2003, 117 Stat. 2355, 2359, 2371; Pub. L. 109–171, title V, § 5204, title VI, § 6034(d)(2), Feb. 8, 2006, 120 Stat. 48, 78; Pub. L. 109–432, div. B, title III, § 303, Dec. 20, 2006, 120 Stat. 2992; Pub. L. 111–148, title VI, § 6402(i), Mar. 23, 2010, 124 Stat. 760; Pub. L. 111–152, title I, § 1303(a)(1), Mar. 30, 2010, 124 Stat. 1057.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(1), (2), (f)(1), and (k)(2)(C), is classified generally to Title 26, Internal Revenue Code. Subtitle F of such Code appears at section 6001 et seq. of Title 26.

Section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(2), is section 801(a) of Pub. L. 108–173, which is set out as a note under this section.

Sections 242(b) and 249(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (k)(2)(A)(ii), are sections 242(b) and 249(b) of Pub. L. 104–191, which are set out as notes under this section.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (k)(2)(D), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, as amended. Title I of the Act is classified generally to subchapter I (§ 1001 et seq.) of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

AMENDMENTS

2010—Subsec. (k)(3)(A)(i)(III). Pub. L. 111–148, § 6402(i)(2)(A)(i), inserted ''and'' at the end.

Subsec. (k)(3)(A)(i)(IV). Pub. L. 111–148, § 6402(i)(2)(A)(ii), substituted ''for each fiscal year after fiscal year 2006'' for ''for each of fiscal years 2007, 2008, 2009, and 2010'' and a period for ''; and''.

Subsec. (k)(3)(A)(i)(V). Pub. L. 111–148, § 6402(i)(2)(A)(iii), struck out subcl. (V) which read as follows: ''for each fiscal year after fiscal year 2010, the limit under this clause for fiscal year 2010.''

Subsec. (k)(3)(A)(ii)(VIII). Pub. L. 111–148, § 6402(i)(2)(B)(i), inserted ''and'' at the end.

Subsec. (k)(3)(A)(ii)(IX). Pub. L. 111–148, § 6402(i)(2)(B)(ii), substituted ''for each fiscal year after fiscal year 2007'' for ''for each of fiscal years 2008, 2009, and 2010'' and a period for ''; and''.

Subsec. (k)(3)(A)(ii)(X). Pub. L. 111–148, § 6402(i)(2)(B)(iii), struck out subcl. (X) which read as follows: ''for each fiscal year after fiscal year 2010, not less than the amount required under this clause for fiscal year 2010.''

Subsec. (k)(3)(B)(vii). Pub. L. 111–148, § 6402(i)(2)(C)(i), inserted ''and'' at the end.

Subsec. (k)(3)(B)(viii). Pub. L. 111–148, § 6402(i)(2)(C)(ii), substituted ''for each fiscal year after fiscal year 2006'' for ''for each of fiscal years 2007, 2008, 2009, and 2010'' and a period for ''; and''.

Subsec. (k)(3)(B)(ix). Pub. L. 111–148, § 6402(i)(2)(C)(iii), struck out cl. (ix) which read as follows: ''for each fiscal year after fiscal year 2010, the amount to be appropriated under this subparagraph for fiscal year 2010.''

Subsec. (k)(4)(A). Pub. L. 111–152, § 1303(a)(1)(B), inserted ''for activities described in paragraph (3)(C) and'' after ''necessary''.

Pub. L. 111–148, § 6402(i)(1)(B), inserted ''until expended'' after ''appropriation''.

Subsec. (k)(4)(C)(ii). Pub. L. 111–148, § 6402(i)(2)(D), added cl. (ii).

Subsec. (k)(7). Pub. L. 111–148, § 6402(i)(1)(A), added par. (7).

Subsec. (k)(8). Pub. L. 111–152, § 1303(a)(1)(A), added par. (8).

2006—Subsec. (k)(3)(A)(i). Pub. L. 109–432, § 303(a)(1), in introductory provisions inserted ''until expended'' after ''without further appropriation'', in subcl. (II) struck out ''and'' at end, in subcl. (III) substituted ''for each of fiscal years 2004, 2005, and 2006'' for ''for each fiscal year after fiscal year 2003'' and semicolon for period at end, and added subcls. (IV) and (V).

Subsec. (k)(3)(A)(ii)(VI) to (X). Pub. L. 109–432, § 303(a)(2), in subcl. (VI) struck out ''and'' at end, in subcl. (VII) substituted ''for each of fiscal years 2003, 2004, 2005, and 2006'' for ''for each fiscal year after fiscal year 2002'' and semicolon for period at end, and added subcls. (VIII) to (X).

Subsec. (k)(3)(B). Pub. L. 109–432, § 303(b), in introductory provisions inserted ''until expended'' after ''without further appropriation'', in cl. (vi) struck out ''and'' at end, in cl. (vii) substituted ''for each of fiscal years 2003, 2004, 2005, and 2006'' for ''for each fiscal year after fiscal year 2002'' and semicolon for period at end, and added cls. (viii) and (ix).

Subsec. (k)(4)(A). Pub. L. 109–171, § 6034(d)(2)(A), substituted ''subparagraphs (B), (C), and (D)'' for ''subparagraph (B)''.

Subsec. (k)(4)(B). Pub. L. 109–171, § 5204(1), substituted ''Subject to subparagraph (C), the amount'' for ''The amount'' in introductory provisions.

Subsec. (k)(4)(C). Pub. L. 109–171, § 5204(2), added subpar. (C).

Subsec. (k)(4)(D). Pub. L. 109–171, § 6034(d)(2)(B), added subpar. (D).

2003—Subsec. (b). Pub. L. 108–173, § 900(e)(1)(D), in fifth sentence of introductory provisions, substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration'', and, in second sentence of concluding provisions, substituted ''Chief Actuary of the Centers for Medicare & Medicaid Services'' for ''Chief Actuarial Officer of the Health Care Financing Administration''.

Subsec. (b)(2). Pub. L. 108–173, § 801(d)(1), inserted at end ''Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.''

Subsec. (k)(3)(A)(i)(I). Pub. L. 108–173, § 736(a)(5)(A), substituted semicolon for comma at end.

Subsec. (k)(3)(A)(ii). Pub. L. 108–173, § 736(a)(5)(B), substituted ''the programs under this subchapter and subchapter XIX'' for ''the Medicare and medicaid programs'' in introductory provisions.

Subsec. (k)(6)(B). Pub. L. 108–173, § 736(a)(6), substituted ''program under this subchapter'' for ''Medicare program under this subchapter''.

1999—Subsec. (k)(2)(C)(i). Pub. L. 106–113 substituted ''section 24(a)'' for ''section 982(a)(6)(B)''.

1997—Subsec. (k)(6). Pub. L. 105–33 inserted ''June 1, 1998, and'' after ''Not later than'' in introductory provisions.

1996—Subsec. (k). Pub. L. 104–191 added subsec. (k).

1994—Subsec. (a). Pub. L. 103–296, § 108(c)(1)(A), substituted ''Commissioner of Social Security'' for ''Secretary of Health and Human Services'' wherever appearing.

Subsec. (b). Pub. L. 103–296, § 108(c)(1)(B), inserted ''the Commissioner of Social Security,'' after ''composed of'' in introductory provisions.

Subsec. (f)(1). Pub. L. 103–296, § 108(c)(1)(C), substituted ''Commissioner of Social Security'' for ''Secretary of Health and Human Services'' in two places.

1990—Subsec. (i). Pub. L. 101–508 inserted at end ''The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.''

1989—Subsec. (b). Pub. L. 101–234 repealed Pub. L. 100–360, § 212(c)(3), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (b). Pub. L. 100–647 inserted after first sentence ''A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term.''

Pub. L. 100–360 inserted after sixth sentence ''Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1395t–2 of this title and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.''

1986—Subsec. (a)(1), (2). Pub. L. 99–514 substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954''.

Subsec. (b). Pub. L. 99–272 struck out provision at end of penultimate sentence that certification shall not refer to economic assumptions underlying Trustee's report.

Subsec. (f)(1). Pub. L. 99–514 substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954'' wherever appearing.

1984—Subsec. (a). Pub. L. 98–369, § 2337(a), in provisions following par. (2) substituted ''from time to time'' for ''monthly on the first day of each calendar month'', ''paid to or deposited into the Treasury'' for ''to be paid

to or deposited into the Treasury during such month'', and struck out provision that all amounts transferred to the Trust Fund under the preceding sentence had to be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund, and the Trust Fund had to pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsec. (c).

Subsec. (a)(1), (2). Pub. L. 98–369, §2663(j)(2)(F)(i), substituted ''Health and Human Services'' for ''Health, Education, and Welfare'' wherever appearing.

Subsec. (c). Pub. L. 98–369, §2354(b)(2), substituted ''under chapter 31 of title 31'' for ''under the Second Liberty Bond Act, as amended''.

Subsecs. (f)(1), (g), (h). Pub. L. 98–369, §2663(j)(2)(F)(i), substituted ''Health and Human Services'' for ''Health, Education, and Welfare'' wherever appearing.

1983—Subsec. (a). Pub. L. 98–21, §141(b)(1)(A), in provisions following par. (2) substituted ''monthly on the first day of each calendar month'' for ''from time to time'', substituted ''to be paid to or deposited into the Treasury during such month'' for ''paid to or deposited into the Treasury'', and inserted provision that all amounts transferred to the Trust Fund under existing provisions shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund; and the Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on Jan. 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsection (c).

Subsec. (b). Pub. L. 98–21, §341(b)(1), substituted in provisions preceding par. (1) ''Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate'' for ''Secretary of Health, Education, and Welfare, all ex officio''.

Pub. L. 98–21, §154(b), inserted at end provision that the report referred to in par. (2) shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable and provided further that the certification shall not refer to economic assumptions underlying the Trustee's report.

Pub. L. 98–21, §341(b)(2), inserted at end provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

Subsec. (j)(1). Pub. L. 98–21, §142(b)(1), substituted reference to January 1988 for reference to January 1983 and inserted '', subject to paragraph (5),'' after ''may''.

Subsec. (j)(2). Pub. L. 98–21, §142(b)(2)(A), substituted ''on the last day of each month after such loan is made'' for ''from time to time'', substituted ''the total interest accrued to such day'' for ''interest'', and inserted ''(even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan)''.

Subsec. (j)(3)(A). Pub. L. 98–21, §142(b)(3), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j)(5). Pub. L. 98–21, §142(b)(4), added par. (5).

1981—Subsec. (j). Pub. L. 97–123 added subsec. (j).

1980—Subsec. (i). Pub. L. 96–265 added subsec. (i).

1978—Subsec. (b). Pub. L. 95–292 substituted ''Administrator of the Health Care Financing Administration'' for ''Commissioner of Social Security'' in provisions preceding par. (1).

1972—Subsec. (a). Pub. L. 92–603 inserted ''such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and'' after ''consist of'' and before ''such amounts'' in provisions preceding par. (1).

1968—Subsec. (b)(2). Pub. L. 90–248 substituted ''April'' for ''March''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(j)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366, provided that: ''The amendment made by this subsection [amending this section] shall take effect as if included in the amendment made by section 201 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1992).''

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101–508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 100–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to members of Board of Trustees of Federal Hospital Insurance Trust Fund serving on such Board as members of the public on or after Nov. 10, 1988, see section 8005(b) of Pub. L. 100–647, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2337(b), July 18, 1984, 98 Stat. 1091, provided that: ''The amendments made by subsection (a) [amending this section] shall become effective on the first day of the month following the month in which this Act is enacted [July 1984].''

Amendment by section 2354(b)(2) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(i) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 141(b) of Pub. L. 98–21 effective on first day of month following April 1983, see section 141(c) of Pub. L. 98–21, set out as a note under section 401 of this title.

Pub. L. 98–21, title I, §142(b)(2)(B), Apr. 20, 1983, 97 Stat. 101, provided that: ''The amendment made by this paragraph [amending this section] shall apply with re-

spect to months beginning more than 30 days after the date of enactment of this Act [Apr. 20, 1983].''

Amendment by sections 154(b) and 341(b) of Pub. L. 98–21 effective Apr. 20, 1983, see sections 154(e) and 341(d) of Pub. L. 98–21, set out as notes under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–123 effective Dec. 29, 1981, see section 1(c) of Pub. L. 97–123, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

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

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to gifts and bequests received after Oct. 30, 1972, see section 132(f) of Pub. L. 92–603, set out as a note under section 401 of this title.

RESTORATION OF MEDICARE TRUST FUNDS

Pub. L. 108–173, title VII, § 734, Dec. 8, 2003, 117 Stat. 2352, provided that:

''(a) DEFINITIONS.—In this section:

''(1) CLERICAL ERROR.—The term 'clerical error' means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

''(2) TRUST FUND.—The term 'Trust Fund' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

''(b) CORRECTION OF TRUST FUND HOLDINGS.—

''(1) IN GENERAL.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary [of Health and Human Services], the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

''(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

''(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

''(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

''(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

''(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error involved had not occurred.

''(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

''(d) CONGRESSIONAL NOTICE.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

''(e) DEADLINE.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act [Dec. 8, 2003]—

''(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

''(2) the appropriation under subsection (c) shall be made.''

INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS

Pub. L. 108–173, title VIII, § 801, Dec. 8, 2003, 117 Stat. 2357, provided that:

''(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

''(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

''(A) the information described in subsection (b); and

''(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

''(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle [subtitle A (§§ 801–804) of title VIII of Pub. L. 108–173, amending this section, section 1395t of this title, and section 1105 of Title 31, Money and Finance, and enacting provisions set out as a note under section 1105 of Title 31], an affirmative determination under paragraph (1)(B) in 2 consecutive annual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

''(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term '7-fiscal-year reporting period' means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

''(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

''(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

''(A) Each fiscal year within the 7-fiscal-year reporting period.

''(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

''(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

''(A) The gross domestic product.

''(B) Private health costs.

''(C) National health expenditures.

''(D) Other appropriate measures.

''(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.], as added by section 101.

''(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

''(c) DEFINITIONS.—For purposes of this section:

''(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term 'excess general revenue medicare funding' means, with respect to a fiscal year, that—

''(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

''(B) 45 percent.

''(2) GENERAL REVENUE MEDICARE FUNDING.—The term 'general revenue medicare funding' means for a year—

''(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

''(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

''(3) DEDICATED MEDICARE FINANCING SOURCES.—The term 'dedicated medicare financing sources' means the following:

''(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

''(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) [set out as a note under section 401 of this title], as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66).

''(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act [42 U.S.C. 1396u–5(c)].

''(D) PREMIUMS.—The following premiums:

''(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section [sic] 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

''(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

''(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.], as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title [42 U.S.C. 1395w–21 et seq.] insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title [42 U.S.C. 1395w–24(b)(1)(C)], as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D–13(b) of such title [42 U.S.C. 1395w–113(b)], as added by section 101.

''(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

''(4) TOTAL MEDICARE OUTLAYS.—The term 'total medicare outlays' means total outlays from the medicare trust funds and shall—

''(A) include payments made to plans under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1);

''(B) include administrative expenditures made in carrying out title XVIII of such Act [42 U.S.C. 1395 et seq.] and Federal outlays under section 1935(b) of such Act [42 U.S.C. 1396u–5(b)], as added by section 103(a)(2); and

''(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

''(5) MEDICARE TRUST FUND.—The term 'medicare trust fund' means—

''(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

''(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

''(d) CONFORMING AMENDMENTS.—

''(1) FEDERAL HOSPITAL INSURANCE TRUST FUND [Amended section 1395i of this title].

''(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND [Amended section 1395t of this title].

''(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.''

CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104–191, title II, § 242(b), Aug. 21, 1996, 110 Stat. 2016, provided that: ''The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).''

PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104–191, title II, § 249(c), Aug. 21, 1996, 110 Stat. 2020, provided that:

''(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made and after all restoration payments (if any) have been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act [42 U.S.C. 1395i(k)(2)(C)], as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

''(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term 'payment of the costs of asset forfeiture' means—

''(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

''(i) contract services;

''(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

''(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

''(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

''(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

''(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

''(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

''(3) RESTORATION PAYMENT.—Notwithstanding any other provision of law, if the Federal health care offense referred to in paragraph (1) resulted in a loss to an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)], the Secretary of the Treasury shall transfer to such employee welfare benefit plan, from the amount realized from the forfeiture of property referred to in paragraph (1), an amount equal to such loss. For purposes of paragraph (1), the term 'restoration payment' means the amount transferred to an employee welfare benefit plan pursuant to this paragraph.''

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Notwithstanding subsec. (b)(2) of this section, the annual report of the Board of Trustees of the Trust Fund required for calendar year 1983 under this section may be filed at any time not later than forty-five days after Apr. 20, 1983, see section 154(d) of Pub. L. 98–21, set out as a note under section 401 of this title.

§ 1395i–1. Authorization of appropriations

There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under this part with respect to individuals who are qualified railroad retirement beneficiaries (as defined in section 426(c)[1] of this title) and who are not, and upon filing application for monthly insurance benefits under section 402 of this title would not be, entitled to such benefits if service as an employee (as defined in the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.]) after December 31, 1936, had been included in the term ''employment'' as defined in this chapter,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss of interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the individuals described in paragraph (1) had not been entitled to benefits under this part.

(Pub. L. 89–97, title I, § 111(d), July 30, 1965, 79 Stat. 343.)

Editorial Notes

REFERENCES IN TEXT

Section 426(c) of this title, referred to in par. (1), was redesignated section 426(d) of this title by Pub. L. 92–603, title II, § 201(b)(5), Oct. 30, 1972, 86 Stat. 1372.

The Railroad Retirement Act of 1937, referred to in par. (1), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally by act June 24, 1937, ch. 382, part I, 50 Stat. 307, and which was classified principally to subchapter III (§ 228a et seq.) of chapter 9 of Title 45, Railroads. The Railroad Retirement Act of 1937 was amended generally and redesignated the Railroad Retirement Act of 1974 by Pub. L. 93–445, title I, Oct. 16, 1974, 88 Stat. 1305. The Railroad Retirement Act of 1974 is classified generally to subchapter IV (§ 231 et seq.) of chapter 9 of title 45. For complete classification of these Acts to the Code, see Tables.

[1] See References in Text note below.

CODIFICATION

Section was enacted as part of the Social Security Amendments of 1965 and also as part of the Health Insurance for the Aged Act, and not as part of the Social Security Act which comprises this chapter.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 89–97, title I, § 111(e), July 30, 1965, 79 Stat. 343, provided that:

''(1) The amendments made by the preceding provisions of this section [enacting this section and section 228s–2 of Title 45, Railroads, and amending section 1395kk of this title and sections 1401, 3101, 3111, 3201, 3211, and 3221 of Title 26, Internal Revenue Code, and section 228e of Title 45] shall apply to the calendar year 1966 or to any subsequent calendar year, but only if the requirement in paragraph (2) has been met with respect to such calendar year.

''(2) The requirement referred to in paragraph (1) shall be deemed to have been met with respect to any calendar year if, as of the October 1 immediately preceding such calendar year, the Railroad Retirement Tax Act [section 3101 et seq. of Title 26] provides that the maximum amount of monthly compensation taxable under such Act during all months of such calendar year will be an amount equal to one-twelfth of the maximum wages which the Federal Insurance Contributions Act [section 3201 et seq. of Title 26] provides may be counted for such calendar year.''

§ 1395i–1a. Repealed. Pub. L. 101–234, title I, § 102(a), Dec. 13, 1989, 103 Stat. 1980

Section, act Aug. 14, 1935, ch. 531, title XVIII, § 1817A, as added July 1, 1988, Pub. L. 100–360, title I, § 112(a), 102 Stat. 698, provided for establishment and operation of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF REPEAL

Repeal effective Jan. 1, 1990, see section 102(d)(1) of Pub. L. 101–234, set out as a note under section 59B of Title 26, Internal Revenue Code.

ADJUSTMENTS FOR INTEREST LOST DUE TO DELAY OF TRANSFERS TO RESERVE FUND DURING 1989

Pub. L. 100–360, title I, § 112(b), July 1, 1988, 102 Stat. 699, which directed Secretary of the Treasury, in July of 1990, to calculate interest lost to Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to lag between outlays (attributable to amendments made by Pub. L. 100–360) from Federal Hospital Insurance Trust Fund during 1989 and transfers made to such Reserve Fund to cover such outlays, and provided that appropriations under subsection (a)(2) of this section include amount so calculated, was repealed by Pub. L. 101–234, title I, § 102(a), Dec. 13, 1989, 103 Stat. 1980.

§ 1395i–2. Hospital insurance benefits for uninsured elderly individuals not otherwise eligible

(a) Individuals eligible to enroll

Every individual who—

(1) has attained the age of 65,

(2) is enrolled under part B of this subchapter,

(3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and

(4) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part. Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i–2a of this title.

(b) Time, manner, and form of enrollment

An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) Period of enrollment; scope of coverage

The provisions of section 1395p of this title (except subsection (f) thereof), section 1395q of this title, subsection (b) of section 1395r of this title, and subsections (f) and (h) of section 1395s of this title shall apply to persons authorized to enroll under this section except that—

(1) individuals who meet the conditions of subsection (a)(1), (3), and (4) on or before the last day of the seventh month after October 1972 may enroll under this part and (if not already so enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after October 30, 1972, and shall end on the last day of the tenth month after October 1972;

(2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after October 1972, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

(A) the first day of the second month after the month in which he enrolls,

(B) July 1, 1973, or

(C) the first day of the first month in which he meets the requirements of subsection (a),

whichever is the latest;

(4) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 426 of this title or section 426a of this title; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement;

(5) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this chapter;

(6) any percent increase effected under section 1395r(b) of this title in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section and shall be subject to reduction in accordance with subsection (d)(6);

(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1395mm of this title with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1395mm of this title with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

(9) in applying the provisions of section 1395r(b) of this title, there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1395mm of this title with an eligible organization.

(d) Monthly premiums

(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that year.

(2) The Secretary shall, during September of each year[1] determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Subject to paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced,

[1] So in original. Probably should be followed by a comma.

issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

(4)(A) In the case of an individual described in subparagraph (B), the monthly premium for a month shall be reduced by the applicable reduction percent specified in the following table:

For a month in:	The applicable reduction percent is:
1994	25 percent
1995	30 percent
1996	35 percent
1997	40 percent
1998 or subsequent year	45 percent.

(B) An individual described in this subparagraph with respect to a month is an individual who establishes to the satisfaction of the Secretary that, as of the last day of the previous month, the individual—

(i) had at least 30 quarters of coverage under subchapter II;

(ii) was married (and had been married for the previous 1-year period) to an individual who had at least 30 quarters of coverage under such subchapter;

(iii) had been married to an individual for a period of at least 1 year (at the time of such individual's death) if at such time the individual had at least 30 quarters of coverage under such subchapter; or

(iv) is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if at such time the individual had at least 30 quarters of coverage under such subchapter.

(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under subchapter XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under subchapter XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under subchapter II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 410(p) of this title, but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 413 of this title;

(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

(C) For purposes of subparagraph (B)(i)(I), the term ''qualified State or local government retirement system'' means a retirement system that—

(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a), the amount of any increase otherwise applicable under section 1395r(b) of this title (as applied and modified by subsection (c)(6) of this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under section 3111(b) of such Code by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

(B) For purposes of this paragraph, the term ''qualified State or local government retiree group'' means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in one or more occupations or other broad classes of employees of—

(i) the State;

(ii) a political subdivision of the State; or

(iii) an agency or instrumentality of the State or political subdivision of the State.

(e) Contract or other arrangement for payment of monthly premiums

Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Deposit of amounts into Treasury

Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(g) Buy-in under this part for qualified medicare beneficiaries

(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1395v(a) of this title under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title).

(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1395v of this title shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

(B) For purposes of this subsection, section 1395v(d)(1) of this title shall be applied by substituting ''section 1395i–2 of this title'' for ''section 1395r of this title'' and ''subsection (c)(6) (with reference to subsection (b) of section 1395r of this title)'' for ''subsection (b)''.

(Aug. 14, 1935, ch. 531, title XVIII, § 1818, as added Pub. L. 92–603, title II, § 202, Oct. 30, 1972, 86 Stat. 1374; amended Pub. L. 98–21, title VI, § 606(a)(3)(D), (b), Apr. 20, 1983, 97 Stat. 170, 171; Pub. L. 98–369, div. B, title III, §§ 2315(e), 2354(b)(3), (4), July 18, 1984, 98 Stat. 1080, 1100; Pub. L. 99–272, title IX, § 9124(a), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, § 4009(j)(9), Dec. 22, 1987, as added Pub. L. 100–360, title IV, § 411(b)(8)(D), July 1, 1988, 102 Stat. 772; Pub. L. 100–360, title I, § 103, July 1, 1988, 102 Stat. 687; Pub. L. 100–485, title VI, § 608(d)(2), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101–239, title VI, §§ 6012(a)(1), 6013(a), Dec. 19, 1989, 103 Stat. 2161, 2163; Pub. L. 101–508, title IV, § 4008(g)(1), (m)(3)(D), Nov. 5, 1990, 104 Stat. 1388–45, 1388–54; Pub. L. 103–66, title XIII, § 13508(a), Aug. 10, 1993, 107 Stat. 579; Pub. L. 105–33, title IV, § 4453(a), Aug. 5, 1997, 111 Stat. 425; Pub. L. 106–554, § 1(a)(6) [title III, § 331(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–502; Pub. L. 108–173, title I, § 101(e)(5), title VII, § 736(a)(7), Dec. 8, 2003, 117 Stat. 2151, 2355.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(6)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2003—Subsec. (a). Pub. L. 108–173, § 101(e)(5), inserted at end of concluding provisions ''Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i–2a of this title.''

Subsec. (d)(6)(A). Pub. L. 108–173, § 736(a)(7)(A), inserted ''of such Code'' after ''3111(b)''.

Subsec. (g)(2)(B). Pub. L. 108–173, § 736(a)(7)(B), substituted ''subsection (b)'' for ''subsection (b).''

2000—Subsec. (c)(6). Pub. L. 106–554, § 1(a)(6) [title III, § 331(a)(1)], inserted ''and shall be subject to reduction in accordance with subsection (d)(6)'' before semicolon.

Subsec. (d)(6). Pub. L. 106–554, § 1(a)(6) [title III, § 331(a)(2)], added par. (6).

1997—Subsec. (d)(2). Pub. L. 105–33, § 4453(a)(1), substituted ''paragraphs (4) and (5)'' for ''paragraph (4)''.

Subsec. (d)(5). Pub. L. 105–33, § 4453(a)(2), added par. (5).

1993—Subsec. (d)(2). Pub. L. 103–66, § 13508(a)(1), substituted ''Subject to paragraph (4), the amount of an individual's monthly premium under this section'' for ''Such amount''.

Subsec. (d)(4). Pub. L. 103–66, § 13508(a)(2), added par. (4).

1990—Subsec. (c)(7) to (9). Pub. L. 101–508, § 4008(g)(1), added pars. (7) to (9).

Subsec. (g)(2)(B). Pub. L. 101–508, § 4008(m)(3)(D), substituted '' 'subsection (c)(6)'' for '' 'subsection (c)''.

1989—Pub. L. 101–239, § 6012(a)(1), inserted ''elderly'' after ''uninsured'' in section catchline.

Subsec. (g). Pub. L. 101–239, § 6013(a), added subsec. (g).

1988—Subsec. (c)(4) to (7). Pub. L. 100–360, § 411(b)(8)(D), added Pub. L. 100–203, § 4009(j)(9), see 1987 Amendment note below.

Subsec. (d). Pub. L. 100–360, § 103, amended subsec. (d) generally. Prior to amendment, subsec. (d) read as follows:

''(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

''(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductible for that following calendar year, as promulgated under section 1395e(b)(2) of this title, to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1.''

Subsec. (d)(1). Pub. L. 100–485 substituted ''during that year'' for ''during that entire year''.

1987—Subsec. (c)(4) to (7). Pub. L. 100–203, § 4009(j)(9), as added by Pub. L. 100–360, § 411(b)(8)(D), redesignated pars. (5) to (7) as (4) to (6), respectively, and struck out former par. (4) which read as follows: ''termination of coverage under this section by the filing of notice that the individual no longer wishes to participate in the hospital insurance program shall take effect at the close of the month following the month in which such notice is filed;''.

1986—Subsec. (c)(7). Pub. L. 99–272 added par. (7).

1984—Subsec. (c). Pub. L. 98–369, § 2315(e), substituted ''subsection (b) of section 1395r of this title'' for ''subsection (a) of section 1395r of this title''.

Subsec. (c)(1). Pub. L. 98–369, § 2354(b)(3), substituted ''October 1972'' for ''the month in which this Act is enacted''.

Subsec. (d)(2). Pub. L. 98–369, § 2354(b)(4), substituted '', if a multiple of 50 cents but not a multiple of $1,'' for ''if midway between multiples of $1''.

1983—Subsec. (c). Pub. L. 98–21, § 606(a)(3)(D), substituted ''subsection (a) of section 1395r'' for ''subsection (c) of section 1395r''.

Subsec. (d)(2). Pub. L. 98–21, § 606(b), substituted ''during the next to last calendar quarter of each year'' for ''during the last calendar quarter of each year, beginning in 1973,'', ''the following calendar year'' for ''the 12-month period commencing July 1 of the next year'', and ''for that following calendar year'' for ''for such next year''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title III, § 331(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–502, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1, 2002.''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4453(b), Aug. 5, 1997, 111 Stat. 426, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act [42 U.S.C. 1395i–2(d)(5)(B)(iii)], as added by subsection (a).''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13508(b), Aug. 10, 1993, 107 Stat. 580, provided that: ''The amendments made by this section [amending this section] shall apply to monthly premiums under section 1818 of the Social Security Act [42 U.S.C. 1395i–2] for months beginning with January 1, 1994.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4008(g)(2), Nov. 5, 1990, 104 Stat. 1388–46, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on February 1, 1991.''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6012(a)(1) of Pub. L. 101–239 effective Dec. 19, 1989, but not applicable so as to provide coverage under this part for any month before July 1990, see section 6012(b) of Pub. L. 101–239, set out as an Effective Date note under section 1395i–2a of this title.

Pub. L. 101–239, title VI, § 6013(c), Dec. 19, 1989, 103 Stat. 2164, provided that: ''The amendments made by this section [amending this section and section 1395v of this title] shall become effective January 1, 1990.''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 103 of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(8)(D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title IX, § 9124(b), Apr. 7, 1986, 100 Stat. 168, provided that:

''(1) The amendment made by subsection (a)(3) [amending this section] shall apply to premiums paid for months beginning with July 1986.

''(2) In applying that amendment, months (before, during, or after April 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2315(e) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendments note under section 1395ww of this title.

Amendment by section 2354(b)(3), (4) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

SPECIAL ENROLLMENT PROVISIONS FOR MERCHANT SEAMEN

Pub. L. 97–248, title I, § 125, Sept. 3, 1982, 96 Stat. 365, provided that:

''(a) Any individual who—

''(1) was entitled to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect on September 30, 1981), including such entitlement on the basis of continuing medical care under 42 C.F.R. § 32.17, at any time during the period beginning on March 10, 1981, and ending on October 1, 1981, and

''(2) as of September 30, 1981, was eligible under section 1818(a) or section 1836 of the Social Security Act [42 U.S.C. 1395i–2(a), 1395*o*] to enroll in the insurance program established by part A or part B, respectively, of title XVIII of that Act [42 U.S.C. 1395c et seq., 1395j et seq.] (hereinafter in this section referred to as the 'respective program'),

may enroll (if not otherwise enrolled) in the respective program during the period beginning on the first day of the first month beginning at least 20 days after the date of the enactment of this Act [Sept. 3, 1982] and ending on December 31, 1982.

''(b)(1) The coverage period under the respective program of an individual who enrolls under subsection (a) shall begin—

''(A) on the first day of the month following the month in which the individual enrolls, or

''(B) on October 1, 1981, if the individual files a request for this subparagraph to apply and pays the monthly premiums for the months so covered.

''(2) The coverage period under the respective program of an individual described in subsection (a) who enrolled in the respective program before the enrollment period described in that subsection shall be retro-

actively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

''(c)(1) For purposes of section 1839(d) of the Social Security Act [42 U.S.C. 1395r(d)] with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

''(2) Paragraph (1) shall not apply to an individual—

''(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

''(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

''(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act [Sept. 3, 1982], shall provide for the dissemination of information—

''(A) to unions and other associations representing or assisting seamen,

''(B) to offices enrolling individuals under the respective programs, and

''(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section,

concerning the special benefits provided under this section.

''(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect before October 1, 1981) by providing—

''(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

''(B) the individual's seamen's papers covering that date, or

''(C) such other reasonable documentation as the Secretary may require.''

§ 1395i–2a. Hospital insurance benefits for disabled individuals who have exhausted other entitlement

(a) Eligibility

Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 426(b) of this title, and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 416(i)(1) of this title), but

(C) whose entitlement under section 426(b) of this title ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b) Enrollment

(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 426(b) of this title will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

(c) Coverage period

(1) The period (in this subsection referred to as a ''coverage period'') during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 426(a) or 426–1 of this title.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day

period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this subchapter.

(3) The provisions of subsections (h), (i), and (m) of section 1395p of this title apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1395i–2 of this title.

(d) Payment of premiums

(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 426(b) of this title.

(2) The provisions of subsections (d) through (f) of section 1395i–2 of this title (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(Aug. 14, 1935, ch. 531, title XVIII, §1818A, as added Pub. L. 101–239, title VI, §6012(a)(2), Dec. 19, 1989, 103 Stat. 2161; amended Pub. L. 101–508, title IV, §4008(m)(3)(C), Nov. 5, 1990, 104 Stat. 1388–54; Pub. L. 116–260, div. CC, title I, §120(a)(2)(C)(i), Dec. 27, 2020, 134 Stat. 2954.)

Editorial Notes

AMENDMENTS

2020—Subsec. (c)(3). Pub. L. 116–260 substituted ''subsections (h), (i), and (m) of section 1395p of this title'' for ''subsections (h) and (i) of section 1395p of this title''.

1990—Subsec. (d)(1)(A). Pub. L. 101–508, §4008(m)(3)(C)(i), inserted ''for enrollment under this section'' after ''Premiums''.

Subsec. (d)(1)(C). Pub. L. 101–508, §4008(m)(3)(C)(ii), struck out subpar. (C) which read as follows: ''For purposes of applying section 1395r(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1395i–2 of this title shall be deemed to include a reference to this section.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 101–239, title VI, §6012(b), Dec. 19, 1989, 103 Stat. 2163, provided that: ''The amendments made by this section [enacting this section and amending section 1395i–2 of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989], but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for any month before July 1990.''

§ 1395i–3. Requirements for, and assuring quality of care in, skilled nursing facilities

(a) "Skilled nursing facility" defined

In this subchapter, the term ''skilled nursing facility'' means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(*l*) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A skilled nursing facility must conduct a comprehensive, accurate, standardized, re-

producible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

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

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be

provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care

(i) In general

Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.

(ii) Exception

To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12)[1] of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this subparagraph shall be subject to annual renewal.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a skilled nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990 for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A skilled nursing facility must provide, for individuals used as a nurse aide[2] by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

(E) Regular in-service education

The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term ''nurse aide'' means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

[1] See References in Text note below.

[2] So in original. Probably should be ''as nurse aides''.

(G) "Licensed health professional" defined

In this paragraph, the term ''licensed health professional'' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician.

(6) Physician supervision and clinical records

A skilled nursing facility must—

(A) require that the medical care of every resident be provided under the supervision of a physician;

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

(7) Required social services

In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of

the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this subchapter) to a portion of the facility that is not such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter.

(B) Notice of rights and services

A skilled nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1396r(e)(6) of this title; and

(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this subchapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs. In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis.

(E) Information respecting advance directives

A skilled nursing facility must comply with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(2) Transfer and discharge rights

(A) In general

A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XIX on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's

health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3); and

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]).

(C) Orientation

A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(3) Access and visitation rights

A skilled nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this subchapter for all individuals regardless of source of payment.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a skilled nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or under a State plan under subchapter XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this subchapter with respect to admissions practices of skilled nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(6) Protection of resident funds

(A) In general

The skilled nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $100 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits[3] all interest earned on

[3] So in original. Probably should be ''credit''.

such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XIX.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) Required notices

If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a–5(b) of this title) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C)[4] Skilled nursing facility administrator

The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(C)[4] Availability of survey, certification, and complaint investigation reports

A skilled nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) Licensing and Life Safety Code

(A) Licensing

A skilled nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

(3) Sanitary and infection control and physical environment

A skilled nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accept-

[4] So in original. Two subpars. (C) have been enacted. See Amendment of Subsection (d)(1) note below.

ed professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to skilled nursing facility requirements

The requirements, referred to in section 1395aa(d) of this title, with respect to a State are as follows:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(4) Skilled nursing facility administrator standards

By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(f) Responsibilities of Secretary relating to skilled nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements

relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training,[5] (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata[6] basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities (subject to clause (iii)), as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a skilled nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1396r(g)(2)(B)(i) of this title, unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section; or

(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1396r(h)(2)(A)(ii) of this title of not less than $5,000, or has been subject to a remedy described in clause (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1396r(h)(1)(B)(i) of this title, or in clause (i), (iii), or (iv) of section 1396r(h)(2)(A) of this title, or

(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the skilled nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of this subchapter) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

[5] So in original. A closing parenthesis probably should appear before the comma.

[6] So in original. Probably should be ''pro rata''.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

(4) Secretarial standards for qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in skilled nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this subchapter for extended care services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Special focus facility program

(A) In general

The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement[7] of this chapter.

(B) Periodic surveys

Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Pursuant to an agreement under section 1395aa of this title, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection,

[7] So in original. Probably should be ''requirements''.

for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Standard survey

(i) In general

Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency

(I) In general

Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

(C) Remedies for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

(4) Investigation of complaints and monitoring compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by skilled nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or subchapter XIX,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a skilled nursing facility under paragraph (1), (2), or (4) of subsection (h), with respect to a skilled nursing facility in the State.

(C) Notice to physicians and skilled nursing facility administrator licensing board

If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(E) Submission of survey and certification information to the Secretary

In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Secretarial authority

(A) In general

With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this subchapter and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing

facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments under this subchapter with respect to all individuals entitled to benefits under this subchapter in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of

the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) Assuring prompt compliance

If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

(E) Repeated noncompliance

In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (B)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(3) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(4) Immediate termination of participation for facility where Secretary finds noncompliance and immediate jeopardy

If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary, subject to section 1320a–7j(h) of this title, shall terminate the facility's participation under this subchapter. If the facility's participation under this subchapter is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this subchapter consistent with the requirements of subsection (c)(2) and section 1320a–7j(h) of this title.

(5) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) Sharing of information

Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XIX, including investigations by State medicaid fraud control units.

(i) Nursing Home Compare website

(1) Inclusion of additional information

(A) In general

The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ''Nursing Home Compare'' Medicare website) (or a successor website),

the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1320a–7j(g) of this title, including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting ''nursing home staff hours per resident day'');

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1320a–7j(f) of this title, including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

(III)[8] the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

(B) Deadline for provision of information

(i) In general

Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after March 23, 2010.

(ii) Exception

The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1320a–7j(g) of this title are implemented.

(2) Review and modification of website

(A) In general

The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before March 23, 2010; and

(ii) not later than 1 year after March 23, 2010, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation

In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

(3) Funding

The Secretary shall transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title a one-time allocation of $11,000,000. The amount shall be available on October 6, 2014. Such sums shall remain available until expended. Such sums shall be used to implement section 1320a–7j(g) of this title.

(j) Construction

Where requirements or obligations under this section are identical to those provided under section 1396r of this title, the fulfillment of those requirements or obligations under section 1396r of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(k) Funding for strike teams

In addition to amounts otherwise available, there is appropriated to the Secretary, out of any monies in the Treasury not otherwise appropriated, $250,000,000, to remain available until expended, for purposes of allocating such amount among the States (including the District of Columbia and each territory of the United States) for such a State to establish and implement a strike team that will be deployed to a skilled nursing facility in the State with diagnosed or suspected cases of COVID–19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing during the emergency period described in section 1320b–5(g)(1)(B) of this section and the 1-

[8] So in original. Probably should be cl. (vi).

year period immediately following the end of such emergency period.

(Aug. 14, 1935, ch. 531, title XVIII, § 1819, as added and amended Pub. L. 100–203, title IV, §§ 4201(a)(3), 4202(a)(2), 4203(a)(2), 4206, Dec. 22, 1987, 101 Stat. 1330–160, 1330–175, 1330–179, 1330–182; Pub. L. 100–360, title IV, § 411(*l*)(1)(A), (2)(A)–(D), (F)–(L)(i), (4), (5), (7), (11), July 1, 1988, 102 Stat. 800–805, as amended Pub. L. 100–485, title VI, § 608(d)(27)(A), (C), (D), (I), (L), Oct. 13, 1988, 102 Stat. 2422, 2423; Pub. L. 101–239, title VI, § 6901(b)(1), (3), (d)(4), Dec. 19, 1989, 103 Stat. 2298, 2301; Pub. L. 101–508, title IV, §§ 4008(h)(1)(B)–(F)(i), (G), (2)(B)–(N), (m)(3)(F)[(E)], 4206(d)(1), Nov. 5, 1990, 104 Stat. 1388–46 to 1388–50, 1388–54, 1388–116; Pub. L. 102–375, title VII, § 708(a)(1)(A), Sept. 30, 1992, 106 Stat. 1291; Pub. L. 103–432, title I, §§ 106(c)(1)(A), (2)(A), (3)(A), (4)(A), (B), (d)(1)–(5), 110(b), Oct. 31, 1994, 108 Stat. 4406–4408; Pub. L. 105–15, § 1, May 15, 1997, 111 Stat. 34; Pub. L. 105–33, title IV, §§ 4432(b)(5)(A), 4755(a), Aug. 5, 1997, 111 Stat. 421, 526; Pub. L. 106–554, § 1(a)(6) [title IX, § 941(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–585; Pub. L. 108–173, title VII, § 736(a)(8), title IX, § 932(c)(2), Dec. 8, 2003, 117 Stat. 2355, 2401; Pub. L. 111–148, title VI, §§ 6101(c)(1)(A), 6103(a)(1), (2)(A), (3), (c)(1), 6111(a), 6113(b), 6121(a), Mar. 23, 2010, 124 Stat. 702, 704, 706, 709, 713, 719, 720; Pub. L. 113–185, § 2(c)(4)(B), Oct. 6, 2014, 128 Stat. 1966; Pub. L. 117–2, title IX, § 9402, Mar. 11, 2021, 135 Stat. 127.)

AMENDMENT OF SUBSECTION (d)(1)

Pub. L. 111–148, title VI, § 6101(c)(1)(A), (2), Mar. 23, 2010, 124 Stat. 702, provided that, effective on the date on which the Secretary of Health and Human Services makes certain information available to the public, subsection (d)(1) of this section is amended by striking subparagraph (B) and redesignating subparagraph (C) relating to skilled nursing facility administrator as subparagraph (B). See 2010 Amendment note and Effective Date of 2010 Amendment note below.

Editorial Notes

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (b)(4)(C)(ii)(IV), (c)(2)(B)(iii)(II), and (g)(5)(B), is Pub. L. 89–73, July 14, 1965, 79 Stat. 218. Section 307(a)(12) of the Act was repealed by Pub. L. 106–501, title III, § 306(5), Nov. 13, 2000, 114 Stat. 2244. Similar provisions are now contained in section 307(a)(9) of the Act, which is classified to section 3027(a)(9) of this title. Titles III and VII of the Act are classified generally to subchapters III (§ 3021 et seq.) and XI (§ 3058 et seq.) of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

Subparagraphs (B), (C), and (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239], referred to in subsec. (e)(2)(A), are set out below.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95–142, which is set out as a note under section 1395x of this title.

AMENDMENTS

2021—Subsec. (k). Pub. L. 117–2 added subsec. (k).

2014—Subsec. (i)(3). Pub. L. 113–185 added par. (3).

2010—Subsec. (b)(5)(F). Pub. L. 111–148, § 6121(a)(2), inserted concluding provisions.

Subsec. (d)(1)(B). Pub. L. 111–148, § 6101(c)(1)(A), redesignated subpar. (C) as (B) and struck out former subpar. (B) which related to required notice to a State licensing agency of change in ownership, control interest, management, or certain positions of responsibility for a skilled nursing facility.

Subsec. (d)(1)(C). Pub. L. 111–148, § 6103(c)(1), added subpar. (C). Former subpar. (C) redesignated (B).

Subsec. (f)(2)(A)(i)(I). Pub. L. 111–148, § 6121(a)(1), inserted ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' after ''curriculum''.

Subsec. (f)(8). Pub. L. 111–148, § 6103(a)(3), added par. (8).

Subsec. (g)(5)(E). Pub. L. 111–148, § 6103(a)(2)(A), added subpar. (E).

Subsec. (h)(2)(B)(ii). Pub. L. 111–148, § 6111(a)(1), designated existing provisions as subcl. (I), inserted heading, substituted ''Subject to subclause (II), the Secretary'' for ''The Secretary'', and added subcls. (II) to (IV).

Subsec. (h)(4). Pub. L. 111–148, § 6113(b), substituted ''the Secretary, subject to section 1320a–7(h) of this title, shall terminate'' for ''the Secretary shall terminate'' and ''subsection (c)(2) and section 1320a–7j(h) of this title'' for ''subsection (c)(2)''.

Subsec. (h)(5). Pub. L. 111–148, § 6111(a)(2), inserted ''(ii)(IV),'' after ''(i),''.

Subsecs. (i), (j). Pub. L. 111–148, § 6103(a)(1), added subsec. (i) and redesignated former subsec. (i) as (j).

2003—Subsec. (b)(4)(C)(i). Pub. L. 108–173, § 736(a)(8)(A), substituted ''at least'' for ''at least at least''.

Subsec. (d)(1)(A). Pub. L. 108–173, § 736(a)(8)(B), substituted ''physical, mental'' for ''physical mental''.

Subsec. (f)(2)(B)(iii). Pub. L. 108–173, § 932(c)(2)(A), substituted ''subparagraphs (C) and (D)'' for ''subparagraph (C)'' in introductory provisions.

Pub. L. 108–173, § 736(a)(8)(C), realigned margins of concluding provisions.

Subsec. (f)(2)(D). Pub. L. 108–173, § 932(c)(2)(B), added subpar. (D).

2000—Subsec. (b)(8). Pub. L. 106–554 added par. (8).

1997—Subsec. (b)(3)(C)(i). Pub. L. 105–33, § 4432(b)(5)(A), substituted ''Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such'' for ''Such'' in introductory provisions.

Subsec. (f)(2)(B)(iii). Pub. L. 105–15, § 1(1), inserted ''subject to subparagraph (C),'' after ''(iii)''.

Subsec. (f)(2)(C). Pub. L. 105–15, § 1(2), added subpar. (C).

Subsec. (g)(1)(D), (E). Pub. L. 105–33, § 4755(a), added subpar. (D) and redesignated former subpar. (D) as (E).

1994—Subsec. (b)(3)(C)(i)(I). Pub. L. 103–432, § 110(b), substituted ''but no later than 14 days'' for ''but no later than not later than 14 days''.

Subsec. (b)(5)(D). Pub. L. 103–432, § 106(d)(1), struck out comma before ''or a new competency evaluation program''.

Subsec. (b)(5)(G). Pub. L. 103–432, § 106(d)(2), substituted ''licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician'' for ''or licensed or certified social worker''.

Subsec. (c)(1)(D). Pub. L. 103–432, § 106(c)(2)(A), inserted at end ''In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis.''

Subsec. (c)(6)(B)(i). Pub. L. 103–432, § 106(c)(3)(A), substituted ''$100'' for ''$50''.

Subsec. (e)(2)(B). Pub. L. 103–432, § 106(c)(4)(A), inserted '', but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection'' after ''individual disputing the findings'' in first sentence.

Subsec. (f)(2)(B)(i). Pub. L. 103–432, § 106(d)(3), substituted ''facilities (subject to clause (iii)),'' for ''facilities,''.

Subsec. (f)(2)(B)(iii)(I)(b). Pub. L. 103–432, § 106(c)(1)(A), inserted before semicolon at end '', unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section''.

Subsec. (f)(2)(B)(iii)(I)(c). Pub. L. 103–432, § 106(d)(4), substituted ''clause'' for ''clauses'' in two places.

Subsec. (g)(1)(C). Pub. L. 103–432, § 106(c)(4)(B), substituted second sentence for former second sentence which read as follows: ''The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations.''

Subsec. (g)(5)(B). Pub. L. 103–432, § 106(d)(5), substituted ''paragraph'' for ''paragraphs'' before ''(1), (2), or (4) of subsection (h)''.

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102–375 substituted ''title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act'' for ''section 307(a)(12) of the Older Americans Act of 1965''.

1990—Subsec. (b)(1)(B). Pub. L. 101–508, § 4008(h)(2)(B), inserted at end ''A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.''

Subsec. (b)(3)(C)(i)(I). Pub. L. 101–508, § 4008(h)(2)(C), substituted ''not later than 14 days'' for ''4 days''.

Subsec. (b)(4)(A)(vii). Pub. L. 101–508, § 4008(h)(2)(D), added cl. (vii).

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101–508, § 4008(h)(2)(E), added subcls. (IV) and (V).

Subsec. (b)(5)(A). Pub. L. 101–508, § 4008(h)(1)(B), designated existing provisions as cl. (i), in introductory provisions substituted ''Except as provided in clause (ii), a skilled nursing facility'' for ''A skilled nursing facility'' and ''on a full-time basis'' for ''(on a full-time, temporary, per diem, or other basis)'', redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101–508, § 4008(h)(1)(C), substituted ''any State registry established under subsection (e)(2)(A) that the facility believes will include information'' for ''the State registry established under subsection (e)(2)(A) as to information in the registry''.

Subsec. (b)(5)(D). Pub. L. 101–508, § 4008(h)(1)(D), inserted before period at end '', or a new competency evaluation program'' after ''and competency evaluation program''.

Subsec. (b)(5)(F)(i). Pub. L. 101–508, § 4008(h)(2)(F), substituted ''(G)) or a registered dietician,'' for ''(G)),''.

Subsec. (c)(1)(A). Pub. L. 101–508, § 4008(h)(2)(G)(B)[(ii)], inserted at end ''A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter.''

Subsec. (c)(1)(A)(iv). Pub. L. 101–508, § 4008(h)(2)(H), inserted before period at end ''and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request''.

Subsec. (c)(1)(A)(x), (xi). Pub. L. 101–508, § 4008(h)(2)(G)(i), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (c)(1)(B)(ii). Pub. L. 101–508, § 4008(h)(2)(I), inserted ''including the notice (if any) of the State developed under section 1396r(e)(6) of this title'' after ''in such rights)''.

Subsec. (c)(1)(E). Pub. L. 101–508, § 4206(d)(1), added subpar. (E).

Subsec. (e)(1)(A). Pub. L. 101–508, § 4008(h)(2)(J), substituted ''subsection (f)(2)'' for ''clause (i) or (ii) of subsection (f)(2)(A)''.

Subsec. (e)(2)(A). Pub. L. 101–508, § 4008(h)(2)(K)(i), inserted before period at end '', or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989''.

Subsec. (e)(2)(C). Pub. L. 101–508, § 4008(h)(2)(K)(ii), added subpar. (C).

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, § 4008(m)(3)(F)[(E)], struck out ''and'' after semicolon at end.

Subsec. (f)(2)(A)(iv). Pub. L. 101–508, § 4008(h)(1)(E), struck out ''and'' at end of subcl. (I), inserted ''who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program'' after ''nurse aide'' and substituted '', and'' for period at end of subcl. (II), and added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101–508, § 4008(h)(1)(G), inserted ''(through subcontract or otherwise)'' after ''may not delegate'' in second sentence.

Subsec. (f)(2)(B)(iii)(I). Pub. L. 101–508, § 4008(h)(1)(F)(i), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: ''offered by or in a skilled nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or''.

Subsec. (g)(1)(C). Pub. L. 101–508, § 4008(h)(2)(L), inserted at end ''A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.''

Subsec. (g)(5)(A)(i). Pub. L. 101–508, § 4008(h)(2)(M), substituted ''deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans'' for ''deficiencies and plans''.

Subsec. (g)(5)(B). Pub. L. 101–508, § 4008(h)(2)(N), substituted ''or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h), with respect'' for ''with respect''.

1989—Subsec. (b)(5)(A). Pub. L. 101–239, § 6901(b)(1)(A), substituted ''October 1, 1990'' for ''January 1, 1990'' in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101–239, § 6901(b)(1)(B), substituted ''January 1, 1990'' and ''October 1, 1990'' for ''July 1, 1989'' and ''January 1, 1990'', respectively.

Subsec. (c)(1)(A)(ii)(II). Pub. L. 101–239, § 6901(d)(4)(A), substituted ''Secretary until such an order could reasonably be obtained)'' for ''Secretary) until such an order could reasonably be obtained''.

Subsec. (c)(1)(A)(v)(I). Pub. L. 101–239, § 6901(d)(4)(B), substituted ''accommodation'' for ''accommodations''.

Subsec. (f)(2)(A)(i)(I). Pub. L. 101–239, § 6901(d)(4)(C), substituted ''and content of the curriculum'' for '', content of the curriculum''.

Pub. L. 101–239, § 6901(b)(3)(A), inserted ''care of cognitively impaired residents,'' after ''social service needs,''.

Subsec. (f)(2)(A)(ii). Pub. L. 101–239, § 6901(b)(3)(B), substituted ''recognition of mental health and social service needs, care of cognitively impaired residents'' for ''cognitive, behavioral and social care''.

Subsec. (f)(2)(A)(iv). Pub. L. 101–239, § 6901(b)(3)(C), (D), added cl. (iv).

Subsec. (h)(2)(C). Pub. L. 101–239, § 6901(d)(4)(D), inserted ''after the effective date of the findings'' after ''6 months'' in introductory provisions.

1988—Subsec. (b)(3)(A)(iii). Pub. L. 100–360, § 411(*l*)(2)(B), struck out ''in the case of a resident eligible for benefits under subchapter XIX of this chapter,'' before ''uses an instrument''.

Subsec. (b)(3)(A)(iv). Pub. L. 100–360, § 411(*l*)(2)(A), as amended by Pub. L. 100–485, § 608(d)(27)(C), struck out ''in the case of a resident eligible for benefits under this part,'' before ''includes the identification''.

Subsec. (b)(3)(B)(ii)(III). Pub. L. 100–360, § 411(*l*)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: ''The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title.''

Subsec. (b)(3)(C)(i)(I). Pub. L. 100–360, §411(*l*)(1)(A)(i), substituted ''than January 1, 1991'' for ''than October 1, 1990''.

Subsec. (b)(4)(C)(i). Pub. L. 100–360, §411(*l*)(1)(A)(ii), substituted ''24-hour licensed nursing'' for ''24-hour nursing'', ''must use'' for ''must employ'', and ''at least 8 consecutive hours a day,'' for ''during the day tour of duty (of at least 8 hours a day)''.

Subsec. (b)(5)(A). Pub. L. 100–360, §411(*l*)(2)(D)(i), as amended by Pub. L. 100–485, §608(d)(27)(D), struck out '', who is not a licensed health professional (as defined in subparagraph (E)),'' after ''any individual''.

Pub. L. 100–360, §411(*l*)(1)(A)(iii), substituted ''January 1, 1990'' for ''October 1, 1989, (or January 1, 1990, in the case of an individual used by the facility as a nurse aide before July 1, 1989)''.

Subsec. (b)(5)(A)(ii). Pub. L. 100–360, §411(*l*)(2)(D)(ii), substituted ''nursing or nursing-related services'' for ''such services''.

Subsec. (b)(5)(G). Pub. L. 100–360, §411(*l*)(2)(D)(iii), inserted ''physical or occupational therapy assistant,'' after ''occupational therapist,''.

Subsec. (c)(1)(D). Pub. L. 100–360, §411(*l*)(1)(A)(iv), as added by Pub. L. 100–485, §608(d)(27)(A), added subpar. (D).

Subsec. (c)(2)(A)(v). Pub. L. 100–360, §411(*l*)(2)(F), substituted ''for a stay at the facility'' for ''an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XIX of this chapter''.

Subsec. (c)(6). Pub. L. 100–360, §411(*l*)(2)(G), substituted ''upon the written'' for ''once the facility accepts the written'' in subpar. (A)(ii), and ''Upon written'' for ''Upon a facility's acceptance of written'' in subpar. (B).

Subsec. (e)(1)(A). Pub. L. 100–360, §411(*l*)(1)(A)(v), formerly §411(*l*)(1)(A)(iv), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''January'' for ''March''.

Subsec. (e)(1)(B). Pub. L. 100–360, §411(*l*)(1)(A)(vi), formerly §411(*l*)(1)(A)(v), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''January'' for ''March''.

Subsec. (e)(2)(A). Pub. L. 100–360, §411(*l*)(1)(A)(vii), formerly §411(*l*)(1)(A)(vi), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''January'' for ''March''.

Subsec. (e)(2)(B). Pub. L. 100–360, §411(*l*)(2)(H), inserted after first sentence ''The State shall make available to the public information in the registry.''

Subsec. (e)(3). Pub. L. 100–360, §411(*l*)(2)(I), inserted ''and discharges'' after ''transfers'' in heading and in two places in text.

Pub. L. 100–360, §411(*l*)(1)(A)(viii), formerly §411(*l*)(1)(A)(vii), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''1989'' for ''1990''.

Subsec. (e)(5). Pub. L. 100–360, §411(*l*)(1)(A)(ix), formerly §411(*l*)(1)(A)(viii), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''1990'' for ''1989'' in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100–360, §411(*l*)(2)(J), substituted ''recognition of mental health and social service needs'' for ''cognitive, behavioral and social care''.

Subsec. (f)(3). Pub. L. 100–360, §411(*l*)(2)(I), inserted ''and discharges'' after ''transfers'' in heading and in text.

Pub. L. 100–360, §411(*l*)(1)(A)(x), formerly §411(*l*)(1)(A)(ix), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''1988'' for ''1989''.

Subsec. (f)(6)(A). Pub. L. 100–360, §411(*l*)(1)(A)(xi), formerly §411(*l*)(1)(A)(x), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''January'' for ''July''.

Subsec. (f)(6)(B). Pub. L. 100–360, §411(*l*)(1)(A)(xii), formerly §411(*l*)(1)(A)(xi), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted ''April'' for ''October''.

Subsec. (f)(7)(A). Pub. L. 100–360, §411(*l*)(2)(K), substituted ''residents'' for ''patients''.

Subsec. (f)(7)(B). Pub. L. 100–360, §411(*l*)(2)(L)(i), substituted ''shall include'' for ''shall not include''.

Subsec. (g)(1)(C). Pub. L. 100–360, §411(*l*)(5)(A)–(C), substituted ''and timely review'' for '', review,'', inserted ''or by another individual used by the facility in providing services to such a resident'' after ''a nursing facility'', and substituted ''The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority.'' for ''If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding.''

Subsec. (g)(1)(D). Pub. L. 100–360, §411(*l*)(5)(D), substituted ''to issue regulations to carry out this subsection'' for ''to establish standards under subsection (f) of this section''.

Subsec. (g)(2)(A)(i). Pub. L. 100–360, §411(*l*)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: ''The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title.''

Subsec. (g)(2)(B)(ii). Pub. L. 100–360, §411(*l*)(5)(F), as added by Pub. L. 100–485, §608(d)(27)(I), substituted ''practicable'' for ''practical''.

Subsec. (g)(2)(C)(i). Pub. L. 100–360, §411(*l*)(4), substituted ''January'' for ''October''.

Subsec. (g)(3)(D). Pub. L. 100–360, §411(*l*)(5)(G), formerly §411(*l*)(5)(F), as redesignated by Pub. L. 100–485, §608(d)(27)(I), substituted ''on the basis of that survey'' for ''on that basis''.

Subsec. (g)(4). Pub. L. 100–360, §411(*l*)(5)(H), formerly §411(*l*)(5)(G), as redesignated by Pub. L. 100–485, §608(d)(27)(I), struck out ''chronically'' after ''enforcement actions against'' in last sentence.

Subsec. (h)(2)(B)(ii). Pub. L. 100–360, §411(*l*)(7)(A), substituted ''. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.'' for ''and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a–7a of this title.''

Subsec. (h)(5). Pub. L. 100–360, §411(*l*)(11), as added by Pub. L. 100–485, §608(d)(27)(L), substituted ''clauses (i), and (iii) of paragraph (2)(B)'' for ''clauses (i), (iii), and (iv) of paragraph (2)(A)''.

Subsec. (h)(6). Pub. L. 100–360, §411(*l*)(7)(B), inserted ''by such facilities'' after ''be made available''.

1987—Subsecs. (g) to (i). Pub. L. 100–203, §§4202(a)(2), 4203(a)(2), 4206, added subsecs. (g), (h), and (i), respectively.

Statutory Notes and Related Subsidiaries

Effective Date of 2010 Amendment

Pub. L. 111–148, title VI, §6101(c)(2), Mar. 23, 2010, 124 Stat. 702, provided that: ''The amendments made by paragraph (1) [amending this section and section 1396r of this title] shall take effect on the date on which the Secretary [of Health and Human Services] makes the information described in subsection (b)(1) [probably means subsec. (b) of section 6101, which is set out as a

note under section 1320a–3 of this title] available to the public under such subsection.''

Pub. L. 111–148, title VI, § 6103(a)(2)(B), Mar. 23, 2010, 124 Stat. 706, provided that: ''The amendment made by this paragraph [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].''

Pub. L. 111–148, title VI, § 6103(c)(3), Mar. 23, 2010, 124 Stat. 710, provided that: ''The amendments made by this subsection [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].''

Pub. L. 111–148, title VI, § 6111(c), Mar. 23, 2010, 124 Stat. 716, provided that: ''The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].''

Amendment by section 6113(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6113(c) of Pub. L. 111–148, set out as a note under section 1320a–7j of this title.

Pub. L. 111–148, title VI, § 6121(c), Mar. 23, 2010, 124 Stat. 721, provided that: ''The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010].''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 932(d), Dec. 8, 2003, 117 Stat. 2402, provided that: ''The amendments made by this section [amending this section and sections 1395cc, 1395ff, and 1396r of this title] shall apply to appeals filed on or after October 1, 2004.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title IX, § 941(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–586, provided that: ''The amendments made by this section [amending this section and section 1396r of this title] shall take effect on January 1, 2003.''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4432(d), Aug. 5, 1997, 111 Stat. 422, provided that: ''The amendments made by this section [amending this section and sections 1395k, 1395*l*, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) [amending this section and sections 1395k, 1395*l*, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] shall apply to items and services furnished on or after July 1, 1998.''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 106(c)(1)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: ''The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

Pub. L. 103–432, title I, § 106(c)(2)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: ''The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA–1987 [Pub. L. 100–203].''

Pub. L. 103–432, title I, § 106(c)(3)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: ''The amendment made by subparagraph (A) [amending this section] shall take effect January 1, 1995.''

Pub. L. 103–432, title I, § 106(c)(4)(C), Oct. 31, 1994, 108 Stat. 4407, provided that: ''The amendments made by this paragraph [amending this section] shall take effect January 1, 1995.''

Pub. L. 103–432, title I, § 106(d)(7), Oct. 31, 1994, 108 Stat. 4407, provided that: ''The amendments made by this subsection [amending this section and provisions set out as a note below] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103–171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102–375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4008(h)(1)(F)(ii), Nov. 5, 1990, 104 Stat. 1388–47, as amended by Pub. L. 103–432, title I, § 106(d)(6), Oct. 31, 1994, 108 Stat. 4407, provided that:

''(I) The amendments made by clause (i) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

''(aa) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.];

''(bb) was subject to a denial of payment under either such title;

''(cc) was assessed a civil money penalty not less than $5,000 for deficiencies in skilled nursing facility standards;

''(dd) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

''(ee) pursuant to State action, was closed or had its residents transferred.

''(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act [42 U.S.C. 1395i–3(f)(2)(B)(iii)(I)] (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility.''

Pub. L. 101–508, title IV, § 4008(h)(1)(H), Nov. 5, 1990, 104 Stat. 1388–48, provided that: ''Except as provided in subparagraph (F) [amending this section and enacting provisions set out as a note above], the amendments made by this subsection [probably means this paragraph, amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Pub. L. 101–508, title IV, § 4008(h)(2)(P), Nov. 5, 1990, 104 Stat. 1388–50, provided that: ''The amendments made by this paragraph [amending this section and sections 1395x and 1395yy of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Pub. L. 101–508, title IV, § 4206(e)(1), Nov. 5, 1990, 104 Stat. 1388–117, provided that: ''The amendments made by subsections (a) and (d) [amending this section and sections 1395cc and 1395bbb of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6901(b)(6), Dec. 19, 1989, 103 Stat. 2300, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

''(B) EXCEPTION.—The amendments made by paragraph (3) [amending this section and section 1396r of this title] shall apply to nurse aide training and com-

petency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act [Dec. 19, 1989], but shall not affect competency evaluations conducted under programs offered before the end of such period.''

Pub. L. 101–239, title VI, § 6901(d)(6), Dec. 19, 1989, 103 Stat. 2301, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396i and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

''(B) EXCEPTION.—The amendment made by paragraph (1) [amending section 1396r of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100–203, title IV, § 4204, Dec. 22, 1987, 101 Stat. 1330–182, as amended by Pub. L. 100–360, title IV, § 411(*l*)(9), July 1, 1988, 102 Stat. 805; Pub. L. 100–485, title VI, § 608(d)(27)(K), Oct. 13, 1988, 102 Stat. 2423, provided that:

''(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i–3], the amendments made by sections 4201 and 4202 [enacting and amending this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title] (relating to skilled nursing facility requirements and survey and certification requirements) shall apply to services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date.

''(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i–3], the amendments made by section 4203 of this Act [amending this section and section 1395aa of this title] apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date.

''(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act [42 U.S.C. 1395x(j)].

''(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part [part 1 of subtitle C (§§ 4201–4206), enacting this section, amending this section and sections 1395x, 1395aa, 1395tt, and 1395yy of this title, and enacting provisions set out as notes under this section] and implementing the amendments made by this part.''

GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS

Pub. L. 111–148, title VI, § 6103(d)(1), (3), Mar. 23, 2010, 124 Stat. 710, provided that:

''(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle [subtitle B (§§ 6101–6121) of title VI of Pub. L. 111–148, enacting section 1320a–7j of this title, amending this section and sections 1320a–3, 1320a–7j, 1395yy, 1396a, and 1396r of this title, and enacting provisions set out as notes under this section and sections 1320a–3, 1320a–7j, and 1396r of this title] referred to as the 'Secretary') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

''(3) DEFINITIONS.—In this subsection:

''(A) NURSING FACILITY.—The term 'nursing facility' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

''(B) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(C) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).''

DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE

Pub. L. 111–148, title VI, § 6103(e), Mar. 23, 2010, 124 Stat. 710, provided that: ''Not later than 1 year after the date of enactment of this Act [Mar. 23, 2010], the Secretary [of Health and Human Services] shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

''(1) The documentation on nursing facilities that is available to the public.

''(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

''(3) General information on consumer rights with respect to nursing facilities.

''(4) The nursing facility survey process (on a national and State-specific basis).

''(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.''

NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES

Pub. L. 111–148, title VI, § 6114, Mar. 23, 2010, 124 Stat. 720, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

''(b) CONDUCT OF DEMONSTRATION PROJECTS.—

''(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

''(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and

nursing facilities who have cognitive impairment, including dementia.

''(c) DURATION AND IMPLEMENTATION.—

''(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

''(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act [Mar. 23, 2010].

''(d) DEFINITIONS.—In this section:

''(1) NURSING FACILITY.—The term 'nursing facility' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

''(2) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(3) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a) [1395i–3(a)]).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

''(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''

REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES

Pub. L. 108–173, title I, §107(b), Dec. 8, 2003, 117 Stat. 2169, provided that:

''(1) REVIEW.—

''(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

''(B) SPECIFIC MATTERS REVIEWED.—In conducting the review under subparagraph (A), the Secretary shall—

''(i) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

''(ii) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

''(2) REPORT.—

''(A) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall submit a report to Congress on the study conducted under paragraph (1)(A).

''(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

''(i) a description of the plans of the Secretary to implement the provisions of this Act [see Tables for classification] in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

''(ii) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.''

STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §107], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that the Secretary of Health and Human Services would conduct a study that identifies variations in State licensure and certification standards for health care providers and other individuals providing respiratory therapy in skilled nursing facilities, examines State requirements relating to respiratory therapy competency examinations for such providers and individuals and determines whether regular respiratory therapy competency examinations or certifications should be required under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and submit a report of the results of the study and any recommendations by 18 months after Nov. 29, 1999.

RETROACTIVE REVIEW

Pub. L. 105–33, title IV, §4755(c), Aug. 5, 1997, 111 Stat. 527, provided that: ''The procedures developed by a State under the amendments made by subsection[s] (a) and (b) [amending this section and section 1396r of this title] shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.''

STUDY AND REPORT ON DEEMING FOR NURSING FACILITIES AND RENAL DIALYSIS FACILITIES

Pub. L. 104–134, title I, §101(d) [title V, §516(d)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–248; renumbered title I, Pub. L. 104–140, §1(a), May 2, 1996, 110 Stat. 1327, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall provide for—

''(A) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying skilled nursing facilities for compliance with the conditions and requirements of sections 1819 and 1861(j) of the Social Security Act [42 U.S.C. 1395i–3, 1395x(j)] and nursing facilities for compliance with the conditions of section 1919 of such Act [42 U.S.C. 1396r], and

''(B) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying renal dialysis facilities for compliance with the conditions and requirements of section 1881(b) of the Social Security Act [42 U.S.C. 1395rr(b)].

''(2) REPORT.—Not later than July 1, 1997, the Secretary shall transmit to Congress a report on each of the studies provided for under paragraph (1). The report on the study under paragraph (1)(A) shall include (and the report on the study under paragraph (1)(B) may include) a specific framework, where appropriate, for implementing a process under which facilities covered under the respective study may be deemed to meet applicable medicare conditions and requirements if they are accredited by a national accreditation body.''

MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES

Pub. L. 101–508, title IV, §4008(h)(2)(O), Nov. 5, 1990, 104 Stat. 1388–50, provided that: ''Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1819(b)(4)(A) of the Social Security Act [42 U.S.C. 1395i–3(b)(4)(A)(ii), (iv), and (v)] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.''

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS; PUBLICATION OF PROPOSED REGULATIONS

Pub. L. 101–239, title VI, §6901(b)(2), Dec. 19, 1989, 103 Stat. 2298, provided that: ''The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in sections 1819(f)(2) and 1919(f)(2) of the Social Security Act [42 U.S.C. 1395i–3(f)(2), 1396r(f)(2)] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989].''

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

Pub. L. 101–239, title VI, § 6901(b)(4)(B)–(D), Dec. 19, 1989, 103 Stat. 2299, provided that:

''(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act [42 U.S.C. 1395i–3(b)(5)(A), 1396r(b)(5)(A)] (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act [42 U.S.C. 1395i–3(e)(1)(A), 1396r(e)(1)(A)]), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for '75 hours' in sections 1819(f)(2) and 1919(f)(2) of such Act [42 U.S.C. 1395i–3(f)(2), 1396r(f)(2)], respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such hours in supervised practical nurse aide training or in regular in-service nurse aide education.

''(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

''(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act [Dec. 19, 1989].''

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Pub. L. 100–203, title IV, § 4201(c), Dec. 22, 1987, 101 Stat. 1330–174, provided that: ''The Secretary of Health and Human Services shall evaluate, and report to Congress by not later than January 1, 1992, on the implementation of the resident assessment process for residents of skilled nursing facilities under the amendments made by this section [enacting this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title].''

ANNUAL REPORT ON STATUTORY COMPLIANCE AND ENFORCEMENT ACTIONS

Pub. L. 100–203, title IV, § 4205, Dec. 22, 1987, 101 Stat. 1330–182, provided that: ''The Secretary of Health and Human Services shall report to the Congress annually on the extent to which skilled nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1819 of the Social Security Act [42 U.S.C. 1395i–3(b), (c), (d)] (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1819(h) of such Act (as added by section 4203 of this Act).''

§ 1395i–3a. Protecting residents of long-term care facilities

(1) National Training Institute for surveyors

(A) In general

The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.].

(B) Activities carried out by the Institute

The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) Grants to State survey agencies

(A) In general

The Secretary of Health and Human Services shall make grants to State agencies that

perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r [1396r]).

(B) Use of funds

A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(Pub. L. 111–148, title VI, § 6703(b)(1), (2), Mar. 23, 2010, 124 Stat. 798, 799.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in par. (1)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to this subchapter (§ 1395 et seq.) and subchapter XIX (§ 1396 et seq.), respectively, of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Elder Justice Act of 2009 and also as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

Statutory Notes and Related Subsidiaries

DEFINITIONS

Pub. L. 111–148, title VI, § 6702, Mar. 23, 2010, 124 Stat. 782, provided that: ''Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act [42 U.S.C. 1397j] (as added by section 6703(a)) and is used in this subtitle [subtitle H (§§ 6701–6703) of title VI of Pub. L. 111–148, enacting this section and sections 1320b–25, 1397j, 1397j–1, 1397k to 1397k–3, 1397*l*, and 1397m to 1397m–5 of this title, amending sections 602, 604, 622, 671 to 673, 1320a–7, 1320a–7a, 1397, 1397a, 1397c to 1397e, and 1397g of this title, and enacting provisions set out as notes under sections 602 and 1305 of this title] has the meaning given such term by such section.''

§ 1395i–4. Medicare rural hospital flexibility program

(a) Establishment

Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

(b) Application

A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

(1) assurances that the State—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

(ii) promotes regionalization of rural health services in the State; and

(iii) improves access to hospital and other health services for rural residents of the State; and

(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

(3) such other information and assurances as the Secretary may require.

(c) Medicare rural hospital flexibility program described

(1) In general

A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

(2) State designation of facilities

(A) In general

A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C), and (D).

(B) Criteria for designation as critical access hospital

A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title, and that—

(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1395x(e) of this title to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1395x(w)(1) of this title; and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1395x(aa)(2)(I) of this title.

(C) Recently closed facilities

A State may designate a facility as a critical access hospital if the facility—

(i) was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(D) Downsized facilities

A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

(i) is licensed by the State as a health clinic or a health center;

(ii) was a hospital that was downsized to a health clinic or health center; and

(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(E) Authority to establish psychiatric and rehabilitation distinct part units

(i) In general

Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v)[1] of section 1395ww(d)(1)(B) of this title, including any regulations adopted by the Secretary under such section.

(ii) Limitation on number of beds

The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

(iii) Exclusion of beds from bed count

In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

(iv) Effect of failure to meet requirements

If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this subchapter to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.

(d) "Rural health network" defined

(1) In general

In this section, the term ''rural health network'' means, with respect to a State, an organization consisting of—

(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

(B) at least 1 hospital that furnishes acute care services.

(2) Agreements

(A) In general

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item de-

[1] See References in Text note below.

scribed in subparagraph (B) with at least 1 hospital that is a member of the network.

(B) Items described

The items described in this subparagraph are the following:

(i) Patient referral and transfer.

(ii) The development and use of communications systems including (where feasible)—

(I) telemetry systems; and

(II) systems for electronic sharing of patient data.

(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

(C) Credentialing and quality assurance

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(i) 1 hospital that is a member of the network;

(ii) 1 peer review organization or equivalent entity; or

(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

(e) Certification by Secretary

The Secretary shall certify a facility as a critical access hospital if the facility—

(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

(2) is designated as a critical access hospital by the State in which it is located; and

(3) meets such other criteria as the Secretary may require.

(f) Permitting maintenance of swing beds

Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

(g) Grants

(1) Medicare rural hospital flexibility program

The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

(A) engaging in activities relating to planning and implementing a rural health care plan;

(B) engaging in activities relating to planning and implementing rural health networks;

(C) designating facilities as critical access hospitals; and

(D) providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking.

(2) Rural emergency medical services

(A) In general

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

(B) Application

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

(3) Upgrading data systems

(A) Grants to hospitals

The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997 and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(B) Eligible small rural hospital defined

For purposes of this paragraph, the term ''eligible small rural hospital'' means a non-Federal, short-term general acute care hospital that—

(i) is located in a rural area (as defined for purposes of section 1395ww(d) of this title); and

(ii) has less than 50 beds.

(C) Application

A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(D) Amount of grant

A grant to a hospital under this paragraph may not exceed $50,000.

(E) Use of funds

A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff

on computer information systems, to offset costs related to the implementation of prospective payment systems and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(F) Reports

(i) Information

A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

(ii) Timing of submission

(I) Interim reports

The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(II) Final report

The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(4) Additional requirements with respect to FLEX grants

With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

(A) Consultation with the state hospital association and rural hospitals on the most appropriate ways to use grants

A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

(B) Limitation on use of grant funds for administrative expenses

A State may not expend more than the lesser of—

(i) 15 percent of the amount of the grant for administrative expenses; or

(ii) the State's federally negotiated indirect rate for administering the grant.

(5) Use of funds for Federal administrative expenses

Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (for each of fiscal years 2005 through 2008) and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.

(6) Providing mental health services and other health services to veterans and other residents of rural areas

(A) Grants to States

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas (as defined for purposes of section 1395ww(d) of this title and including areas that are rural census tracks, as defined by the Administrator of the Health Resources and Services Administration), including for the provision of crisis intervention services and the detection of post-traumatic stress disorder, traumatic brain injury, and other signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas.

(B) Application

(i) In general

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii) and (A)(iii) of subsection (b)(1).

(ii) Consideration of regional approaches, networks, or technology

The Secretary may, as appropriate in awarding grants to States under subparagraph (A), consider whether the application submitted by a State under this subparagraph includes 1 or more proposals that utilize regional approaches, networks, health information technology, telehealth, or telemedicine to deliver services described in subparagraph (A) to individuals described in that subparagraph. For purposes of this clause, a network may, as the Secretary determines appropriate, include Federally qualified health centers (as defined in section 1395x(aa)(4) of this title), rural health clinics (as defined in section 1395x(aa)(2) of this title), home health agencies (as defined in section 1395x(*o*) of this title), community mental health centers (as defined in section 1395x(ff)(3)(B) of this title) and other providers of mental health services, pharmacists, local government, and other providers deemed necessary to meet the needs of veterans.

(iii) Coordination at local level

The Secretary shall require, as appropriate, a State to demonstrate consultation with the hospital association of such State, rural hospitals located in such State, providers of mental health services, or other appropriate stakeholders for the provision of services under a grant awarded under this paragraph.

(iv) Special consideration of certain applications

In awarding grants to States under subparagraph (A), the Secretary shall give special consideration to applications submitted by States in which veterans make up a high percentage (as determined by the Secretary) of the total population of the State. Such consideration shall be given without regard to the number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in the areas in which mental health services and other health care services would be delivered under the application.

(C) Coordination with VA

The Secretary shall, as appropriate, consult with the Director of the Office of Rural Health of the Department of Veterans Affairs in awarding and administering grants to States under subparagraph (A).

(D) Use of funds

A State awarded a grant under this paragraph may, as appropriate, use the funds to reimburse providers of services described in subparagraph (A) to individuals described in that subparagraph.

(E) Limitation on use of grant funds for administrative expenses

A State awarded a grant under this paragraph may not expend more than 15 percent of the amount of the grant for administrative expenses.

(F) Independent evaluation and final report

The Secretary shall provide for an independent evaluation of the grants awarded under subparagraph (A). Not later than 1 year after the date on which the last grant is awarded to a State under such subparagraph, the Secretary shall submit a report to Congress on such evaluation. Such report shall include an assessment of the impact of such grants on increasing the delivery of mental health services and other health services to veterans of the United States Armed Forces living in rural areas (as so defined and including such areas that are rural census tracks), with particular emphasis on the impact of such grants on the delivery of such services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, and to other individuals living in such rural areas.

(7) Critical access hospitals transitioning to skilled nursing facilities and assisted living facilities

(A) Grants

The Secretary may award grants to eligible critical access hospitals that have submitted applications in accordance with subparagraph (B) for assisting such hospitals in the transition to skilled nursing facilities and assisted living facilities.

(B) Application

An applicable critical access hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(C) Additional requirements

The Secretary may not award a grant under this paragraph to an eligible critical access hospital unless—

(i) local organizations or the State in which the hospital is located provides matching funds; and

(ii) the hospital provides assurances that it will surrender critical access hospital status under this subchapter within 180 days of receiving the grant.

(D) Amount of grant

A grant to an eligible critical access hospital under this paragraph may not exceed $1,000,000.

(E) Funding

There are appropriated from the Federal Hospital Insurance Trust Fund under section 1395i of this title for making grants under this paragraph, $5,000,000 for fiscal year 2008.

(F) Eligible critical access hospital defined

For purposes of this paragraph, the term ''eligible critical access hospital'' means a critical access hospital that has an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0.

(h) Grandfathering provisions

(1) In general

Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to August 5, 1997, shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

(2) Continuation of medical assistance facility and rural primary care hospital terms

Notwithstanding any other provision of this subchapter, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this subchapter to a ''critical access hospital'' shall be deemed to be a reference to a ''medical assistance facility'' or ''rural primary care hospital''.

(3) State authority to waive 35-mile rule

In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date,

the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(i) Waiver of conflicting part A provisions

The Secretary is authorized to waive such provisions of this part and part E as are necessary to conduct the program established under this section.

(j) Authorization of appropriations

There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002, for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008, for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1820, as added Pub. L. 101–239, title VI, § 6003(g)(1)(A), Dec. 19, 1989, 103 Stat. 2145; amended Pub. L. 101–508, title IV, § 4008(d)(1)–(3), (m)(2)(B), Nov. 5, 1990, 104 Stat. 1388–44, 1388–45, 1388–53; Pub. L. 103–432, title I, § 102(a)(1), (2), (b)(1)(A), (2), (c), (f), (h), Oct. 31, 1994, 108 Stat. 4401–4404; Pub. L. 105–33, title IV, §§ 4002(f)(1), 4201(a), Aug. 5, 1997, 111 Stat. 329, 369; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(a), title IV, §§ 401(b)(2), 403(a)(1), (b), (c), 409], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, 1501A–369, 1501A–370, 1501A–375; Pub. L. 108–173, title I, § 101(e)(1), title IV, § 405(e)(1), (2), (f), (g)(1), (h), Dec. 8, 2003, 117 Stat. 2150, 2267–2269; Pub. L. 110–275, title I, § 121, July 15, 2008, 122 Stat. 2511; Pub. L. 111–148, title III, § 3129(a), (b), Mar. 23, 2010, 124 Stat. 426.)

Editorial Notes

REFERENCES IN TEXT

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (c)(2)(E)(i), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, § 15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

The Balanced Budget Act of 1997, referred to in subsec. (g)(3)(A), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subsec. (g)(3)(A), (E), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (h)(3), is section 405(h)(1) of Pub. L. 108–173, which amended this section. See 2003 Amendment note below.

AMENDMENTS

2010—Subsec. (g)(3)(A). Pub. L. 111–148, § 3129(b)(1), inserted ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary'' before period at end.

Subsec. (g)(3)(E). Pub. L. 111–148, § 3129(b)(2), substituted '', to offset'' for '', and to offset'' and inserted ''and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary'' before period at end.

Subsec. (j). Pub. L. 111–148, § 3129(a), substituted ''2010, for'' for ''2010, and for'' and inserted ''and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended'' before period at end.

2008—Subsec. (g)(1)(D). Pub. L. 110–275, § 121(d), added subpar. (D).

Subsec. (g)(5). Pub. L. 110–275, § 121(b)(2), which directed insertion of ''and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009)'' after ''2005)'', was executed by making the insertion after ''2008)'' to reflect the probable intent of Congress and the amendment by section 121(b)(1) of Pub. L. 110–275. See note below.

Pub. L. 110–275, § 121(b)(1), substituted ''for each of fiscal years 2005 through 2008'' for ''beginning with fiscal year 2005''.

Subsec. (g)(6). Pub. L. 110–275, § 121(a), added par. (6).

Subsec. (g)(7). Pub. L. 110–275, § 121(e), added par. (7).

Subsec. (j). Pub. L. 110–275, § 121(c), substituted ''2002, for'' for ''2002, and for'' and inserted '', for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, and for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended'' before period at end.

2003—Subsec. (c)(2)(B)(i)(II). Pub. L. 108–173, § 405(h)(1), inserted ''before January 1, 2006,'' after ''is certified''.

Subsec. (c)(2)(B)(iii). Pub. L. 108–173, § 405(e)(1), substituted ''25'' for ''15 (or, in the case of a facility under an agreement described in subsection (f) of this section, 25)''.

Subsec. (c)(2)(E). Pub. L. 108–173, § 405(g)(1), added subpar. (E).

Subsec. (f). Pub. L. 108–173, § 405(e)(2), struck out ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds'' after ''does not exceed 25 beds''.

Subsec. (g)(4), (5). Pub. L. 108–173, § 405(f)(2), added pars. (4) and (5).

Subsec. (h). Pub. L. 108–173, § 405(h)(2)(A), substituted ''provisions'' for ''of certain facilities'' in heading.

Subsec. (h)(3). Pub. L. 108–173, § 405(h)(2)(B), added par. (3).

Subsec. (i). Pub. L. 108–173, § 101(e)(1), substituted ''part E'' for ''part D''.

Subsec. (j). Pub. L. 108–173, § 405(f)(1), inserted before period at end '', and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008''.

1999—Subsec. (c)(2)(A). Pub. L. 106–113, § 1000(a)(6) [title IV, § 403(c)(1)], substituted ''subparagraphs (B), (C), and (D)'' for ''subparagraph (B)''.

Subsec. (c)(2)(B)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(b)], substituted ''hospital'' for ''nonprofit or public hospital''.

Pub. L. 106–113, §1000(a)(6) [title IV, §401(b)(2)], inserted ''or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title'' after ''section 1395ww(d)(2)(D) of this title)''.

Pub. L. 106–113, §1000(a)(6) [title III, §321(a)], substituted ''that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title), and that'' for ''and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that''.

Subsec. (c)(2)(B)(iii). Pub. L. 106–113, §1000(a)(6) [title IV, §403(a)(1)], substituted ''for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;'' for ''for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;''.

Subsec. (c)(2)(C), (D). Pub. L. 106–113, §1000(a)(6) [title IV, §403(c)(2)], added subpars. (C) and (D).

Subsec. (g)(3). Pub. L. 106–113, §1000(a)(6) [title IV, §409], added par. (3).

1997—Pub. L. 105–33, §4201(a), amended section catchline and text generally, substituting provisions relating to medicare rural hospital flexibility program for provisions relating to essential access community hospital program.

Subsec. (j). Pub. L. 105–33, §4002(f)(1), substituted ''part D'' for ''part C''.

1994—Subsec. (c)(1). Pub. L. 103–432, §102(b)(2)(B)(i), substituted ''paragraph (3) or subsection (k) of this section'' for ''paragraph (3)''.

Subsec. (e)(1). Pub. L. 103–432, §102(b)(1)(A)(i), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: ''is located in a rural area (as defined in section 1395ww(d)(2)(D) of this title);''.

Subsec. (e)(1)(A). Pub. L. 103–432, §102(b)(1)(A)(ii), substituted ''except in the case of a hospital located in an urban area, is located'' for ''is located'' in introductory provisions, substituted ''or (ii)'' for '', (ii)'', and struck out ''or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section,'' after ''section 1395ww(d)(5)(C) of this title,''.

Subsec. (e)(2) to (6). Pub. L. 103–432, §102(b)(1)(A)(i), redesignated pars. (2) to (6) as (1) to (5), respectively.

Subsec. (f)(1)(F). Pub. L. 103–432, §102(a)(1), amended subpar. (F) generally. Prior to amendment, subpar. (F) read as follows: ''provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;''.

Subsec. (f)(1)(H). Pub. L. 103–432, §102(f), inserted before period at end '', except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1395x(r)(1) of this title''.

Subsec. (f)(3). Pub. L. 103–432, §102(c), substituted ''because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.'' for ''because the facility has entered into an agreement with the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.''

Subsec. (f)(4). Pub. L. 103–432, §102(a)(2), added par. (4).

Subsec. (i)(1)(A). Pub. L. 103–432, §102(b)(2)(B)(ii), in cl. (i) inserted ''(except as provided in subsection (k) of this section)'' and in cl. (ii) inserted ''or subsection (k) of this section''.

Subsec. (i)(1)(B). Pub. L. 103–432, §102(b)(1)(A)(iii), substituted ''paragraph (2)'' for ''paragraph (3)''.

Subsec. (i)(2)(A). Pub. L. 103–432, §102(b)(2)(B)(ii), in cl. (i) inserted ''(except as provided in subsection (k) of this section)'' and in cl. (ii) inserted ''or subsection (k) of this section''.

Subsec. (k). Pub. L. 103–432, §102(b)(2)(A)(ii), added subsec. (k). Former subsec. (k) redesignated (*l*).

Subsec. (*l*). Pub. L. 103–432, §102(h), substituted ''1990 through 1997'' for ''1990, 1991, and 1992'' in introductory provisions.

Pub. L. 103–432, §102(b)(2)(A)(i), redesignated subsec. (k) as (*l*).

1990—Subsec. (d)(1). Pub. L. 101–508, §4008(m)(2)(B)(i), struck out ''demonstration'' before ''program''.

Subsec. (f)(1)(A). Pub. L. 101–508, §4008(d)(3), inserted before semicolon at end '', or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas''.

Subsec. (f)(1)(B). Pub. L. 101–508, §4008(d)(2), which directed the substitution of ''is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),'' for ''is a hospital,'' was executed by making the substitution for ''is a hospital'' to reflect the probable intent of Congress.

Subsec. (g)(1)(A)(ii). Pub. L. 101–508, §4008(m)(2)(B)(ii), substituted ''regional referral center'' for ''rural referral center''.

Subsec. (i)(2)(C). Pub. L. 101–508, §4008(d)(1), inserted at end ''In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) of this section with a rural health network located in a State receiving a grant under subsection (a)(1) of this section.''

Subsec. (j). Pub. L. 101–508, §4008(m)(2)(B)(iii), inserted ''and part C of this subchapter'' after ''this part''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3129(c), Mar. 23, 2010, 124 Stat. 427, provided that: ''The amendments made by this section [amending this section] shall apply to grants made on or after January 1, 2010.''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §405(e)(3), Dec. 8, 2003, 117 Stat. 2267, provided that: ''The amendments made by this subsection [amending this section] shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.''

Amendment by section 405(g)(1) of Pub. L. 108–173 applicable to cost reporting periods beginning on or after Oct. 1, 2004, see section 405(g)(3) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(a)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §401(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–369, provided that: ''The amendments made by this section [amending this section and sections 1395*l* and 1395ww of this title] shall become effective on January 1, 2000.''

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–370, provided that: ''The amendment made by paragraph (1) [amending this section] takes effect on the date of the enactment of this Act [Nov. 29, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(d)(4), Nov. 5, 1990, 104 Stat. 1388–45, provided that: ''The amendments made by paragraphs (1), (2), and (3) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].''

DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES

Pub. L. 110–275, title I, §123, July 15, 2008, 122 Stat. 2514, as amended by Pub. L. 111–148, title III, §3126, Mar. 23, 2010, 124 Stat. 425; Pub. L. 116–260, div. CC, title I, §129, Dec. 27, 2020, 134 Stat. 2972, provided that:

''(a) IN GENERAL.—The Secretary shall establish a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating the delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries.

''(b) PURPOSE.—The purpose of the demonstration project under this section is to—

''(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, extended care, and other essential health care services provided under the Medicare and Medicaid programs in eligible counties; and

''(2) evaluate regulatory challenges facing such providers and the communities they serve.

''(c) REQUIREMENTS.—The following requirements shall apply under the demonstration project:

''(1) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall (when determined appropriate by the Secretary), instead of the payment rates otherwise applicable under the Medicare program, be reimbursed at a rate that covers at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries.

''(2) Methods to coordinate the survey and certification process under the Medicare program and the Medicaid program across all health service categories included in the demonstration project shall be tested with the goal of assuring quality and safety while reducing administrative burdens, as appropriate, related to completing such survey and certification process.

''(3) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) and the Secretary shall work with the State to explore ways to revise reimbursement policies under the Medicaid program to improve access to the range of health care services available in such eligible counties.

''(4) The Secretary shall identify regulatory requirements that may be revised appropriately to improve access to care in eligible counties.

''(5) Other essential health care services necessary to ensure access to the range of health care services in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall be identified. Ways to ensure adequate funding for such services shall also be explored.

''(d) APPLICATION PROCESS.—

''(1) ELIGIBILITY.—

''(A) IN GENERAL.—Eligibility to participate in the demonstration project under this section shall be limited to eligible entities.

''(B) ELIGIBLE ENTITY DEFINED.—Subject to subparagraph (C), in this section, the term 'eligible entity' means an entity that—

''(i) is a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)); and

''(ii) is located in a State in which at least 65 percent of the counties in the State are counties that have 6 or less residents per square mile.

''(C) EXTENSION PERIOD.—An entity shall only be eligible to participate in the demonstration project under this section during the extension period if the entity participated in the demonstration project under this section during the initial period.

''(2) APPLICATION.—

''(A) IN GENERAL.—An eligible entity seeking to participate in the demonstration project under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(B) LIMITATION.—The Secretary shall select eligible entities located in not more than 4 States to participate in the demonstration project under this section.

''(3) SELECTION OF ELIGIBLE COUNTIES.—An eligible entity selected by the Secretary to participate in the demonstration project under this section shall select eligible counties in the State in which the entity is located in which to conduct the demonstration project.

''(4) ELIGIBLE COUNTY DEFINED.—In this section, the term 'eligible county' means a county that meets the following requirements:

''(A) The county has 6 or less residents per square mile.

''(B) As of the date of the enactment of this Act [July 15, 2008], a facility designated as a critical access hospital which meets the following requirements was located in the county:

''(i) As of the date of the enactment of this Act, the critical access hospital furnished 1 or more of the following:

''(I) Home health services.

''(II) Hospice care.

''(ii) As of the date of the enactment of this Act, the critical access hospital has an average daily inpatient census of 5 or less.

''(C) As of the date of the enactment of this Act, skilled nursing facility services were available in the county in—

''(i) a critical access hospital using swing beds; or

''(ii) a local nursing home.

''(e) ADMINISTRATION.—

''(1) IN GENERAL.—The demonstration project under this section shall be administered jointly by the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services, in accordance with paragraphs (2) and (3).

''(2) HRSA DUTIES.—In administering the demonstration project under this section, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration shall—

''(A) award grants to the eligible entities selected to participate in the demonstration project; and

''(B) work with such entities to provide technical assistance related to the requirements under the project.

''(3) CMS DUTIES.—In administering the demonstration project under this section, the Administrator of the Centers for Medicare & Medicaid Services shall determine which provisions of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) the Secretary should waive under the waiver authority under subsection (i) that are relevant to the development of alternative reimbursement methodologies, which may include, as appropriate, covering at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries and coordinating the survey and certification process under the Medicare and Medicaid programs, as appropriate, across all service categories included in the demonstration project.

''(f) DURATION.—

''(1) IN GENERAL.—The demonstration project under this section shall be conducted for a 3-year period beginning on August 1, 2016 (referred to in this section as the 'initial period'), and 5-year period beginning on July 1, 2021 (referred to in this section as the 'extension period').

''(2) BEGINNING DATE OF DEMONSTRATION PROJECT.—

''(A) INITIAL PERIOD.—During the initial period, the demonstration project under this section shall be considered to have begun in a State on the date on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

''(B) EXTENSION PERIOD.—During the extension period, the demonstration project under this section shall be considered to have begun in a State on the date during such period on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

''(3) RE-ENTRY ON A ROLLING BASIS FOR EXTENSION PERIOD.—A critical access hospital participating in the demonstration project under this section during the extension period shall begin such participation in the cost reporting year that begins on or after July 1, 2021.

''(g) FUNDING.—

''(1) CMS.—

''(A) INITIAL PERIOD.—The Secretary shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of such sums as are necessary for the costs to the Centers for Medicare & Medicaid Services of carrying out its duties under the demonstration project under this section with respect to the initial period.

''(B) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration project under this section was not implemented.

''(C) EXTENSION PERIOD.—The Secretary shall provide for the transfer of $10,000,000, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services for the purposes of carrying out its duties under the demonstration project under this section with respect to the extension period.

''(2) HRSA.—There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration $800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office under the demonstration project under this section, to remain available for the duration of the demonstration project.

''(h) REPORT.—

''(1) INTERIM REPORT.—Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on the status of the demonstration project that includes initial recommendations on ways to improve access to, and the availability of, health care services in eligible counties based on the findings of the demonstration project.

''(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(i) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary and appropriate for the purpose of carrying out the demonstration project under this section.

''(j) DEFINITIONS.—In this section:

''(1) EXTENDED CARE SERVICES.—The term 'extended care services' means the following:

''(A) Home health services.

''(B) Covered skilled nursing facility services.

''(C) Hospice care.

''(2) COVERED SKILLED NURSING FACILITY SERVICES.—The term 'covered skilled nursing facility services' has the meaning given such term in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)).

''(3) CRITICAL ACCESS HOSPITAL.—The term 'critical access hospital' means a facility designated as a critical access hospital under section 1820(c) of such Act (42 U.S.C. 1395i–4(c)).

''(4) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given such term in section 1861(m) of such Act (42 U.S.C. 1395x(m)).

''(5) HOSPICE CARE.—The term 'hospice care' has the meaning given such term in section 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

''(6) MEDICAID PROGRAM.—The term 'Medicaid program' means the program under title XIX of such Act (42 U.S.C. 1396 et seq.).

''(7) MEDICARE PROGRAM.—The term 'Medicare program' means the program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

''(8) OTHER ESSENTIAL HEALTH CARE SERVICES.—The term 'other essential health care services' means the following:

''(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))[)].

''(C) Public health services (as defined by the Secretary).

''(D) Other health care services determined appropriate by the Secretary.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.''

[Pub. L. 111–148, title III, §3126(b)(1), Mar. 23, 2010, 124 Stat. 426, which directed amendment of section 123 of Pub. L. 111–275, set out above, by striking out subsec. (d)(4)(B)(i)(3)(III), was executed by striking out subsec. (d)(4)(B)(i)(III) to reflect the probable intent of Congress.]

GAO STUDY ON CERTAIN ELIGIBILITY REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS

Pub. L. 106–554, §1(a)(6) [title II, §206], Dec. 21, 2000, 114 Stat. 2763, 2763A–483, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a study on the eligibility requirements for critical access hospitals under section 1820(c) of the Social Security Act (42 U.S.C. 1395i–4(c)) with respect to limitations on average length of stay and number of beds in such a hospital, including an analysis of—

''(1) the feasibility of having a distinct part unit as part of a critical access hospital for purposes of the medicare program under title XVIII of such Act [this subchapter]; and

''(2) the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limitations on average annual length of stay and number of beds.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) together with recommendations regarding—

''(1) whether distinct part units should be permitted as part of a critical access hospital under the medicare program;

''(2) if so permitted, the payment methodologies that should apply with respect to services provided by such units;

''(3) whether, and to what extent, such units should be included in or excluded from the bed limits applicable to critical access hospitals under the medicare program; and

''(4) any adjustments to such eligibility requirements to account for seasonal variations in patient admissions.''

TRANSITION FOR MAF

Pub. L. 105–33, title IV, §4201(c)(6), Aug. 5, 1997, 111 Stat. 374, provided that:

''(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act [Aug. 5, 1997], operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508] (42 U.S.C. 1395b–1 note) from such demonstration to the program established under subsection (a) [amending this section]. At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

''(B) TRANSITION PERIOD DESCRIBED.—

''(i) INITIAL PERIOD.—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

''(ii) EXTENSION.—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period.''

GAO REPORTS

Pub. L. 103–432, title I, §102(a)(4), Oct. 31, 1994, 108 Stat. 4402, directed Comptroller General to submit to Congress, not later than 2 years after Oct. 31, 1994, reports on application of requirements under subsec. (f) of this section that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain average length of inpatient stay during a year that does not exceed 72 hours, and extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited ability of such hospitals to provide needed services.

§ 1395i–5. Conditions for coverage of religious nonmedical health care institutional services

(a) In general

Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution and for home health services furnished an individual by a religious nonmedical health care institution only if—

(1) the individual has an election in effect for such benefits under subsection (b); and

(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services, extended care services, or home health services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility, or receiving services from a home health agency, that was not such an institution.

(b) Election

(1) In general

An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

(2) Form

The election form under this subsection shall include the following:

(A) A written statement, signed by the individual (or such individual's legal representative), that—

(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

(3) Revocation

An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this subchapter.

(4) Limitation on subsequent elections

Once an individual's election under this subsection has been made and revoked twice—

(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

(5) Excepted medical treatment

For purposes of this subsection:

(A) Excepted medical treatment

The term ''excepted medical treatment'' means medical care or treatment (including medical and other health services)—

(i) received involuntarily, or

(ii) required under Federal or State law or law of a political subdivision of a State.

(B) Nonexcepted medical treatment

The term ''nonexcepted medical treatment'' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

(c) Monitoring and safeguard against excessive expenditures

(1) Estimate of expenditures

Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

(2) Adjustment in payments

(A) Proportional adjustment

If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

(B) Alternative adjustments

The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

(C) Trigger level

For purposes of this subsection—

(i) In general

Subject to adjustment under paragraph (3)(B), the ''trigger level'' for a year is the unadjusted trigger level described in clause (ii).

(ii) Unadjusted trigger level

The ''unadjusted trigger level'' for—

(I) fiscal year 1998, is $20,000,000, or

(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

(D) Prohibition of administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

(E) Effect on billing

Notwithstanding any other provision of this subchapter, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

(3) Monitoring expenditure level

(A) In general

The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

(B) Adjustment in trigger level

(i) In general

If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

(ii) Limitation on carryforward

In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

(d) Sunset

If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

(e) Annual report

At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State

plans under subchapter XIX. Such report shall include—

(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

(2) trends in such level; and

(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.

(Aug. 14, 1935, ch. 531, title XVIII, § 1821, as added Pub. L. 105–33, title IV, § 4454(a)(2), Aug. 5, 1997, 111 Stat. 428; amended Pub. L. 108–173, title VII, § 706(a), Dec. 8, 2003, 117 Stat. 2339.)

Editorial Notes

AMENDMENTS

2003—Subsec. (a). Pub. L. 108–173, § 706(a)(1), inserted ''and for home health services furnished an individual by a religious nonmedical health care institution'' after ''religious nonmedical health care institution'' in introductory provisions.

Subsec. (a)(2). Pub. L. 108–173, § 706(a)(2), substituted '', extended care services, or home health services'' for ''or extended care services'' and inserted '', or receiving services from a home health agency,'' after ''skilled nursing facility''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 105–33, title IV, § 4454(d), Aug. 5, 1997, 111 Stat. 431, provided that: ''The amendments made by this section [enacting this section and amending sections 1320a–1, 1320c–11, 1395x, 1396a, and 1396g of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act [42 U.S.C. 1395i–5(b)].''

§ 1395i–6. Hospice program survey and enforcement procedures

(a) Surveys

(1) Frequency

Any entity that is certified as a hospice program (as defined in section 1395x(dd)(2)) of this title shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months.

(2) Public transparency of survey and certification information

(A) Submission of information to the Secretary

(i) In general

Each State or local survey agency, and each national accreditation body with respect to which the Secretary has made a finding under section 1395bb(a) of this title respecting the accreditation of a hospice program by such body, shall submit, in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph, information respecting any survey or certification made with respect to a hospice program by such survey agency or body, as applicable. Such information shall include any inspection report made by such survey agency or body with respect to such survey or certification, any enforcement actions taken as a result of such survey or certification, and any other information determined appropriate by the Secretary.

(ii) Required inclusion of specified form

With respect to a survey under this subsection carried out by a national accreditation body described in clause (i) on or after October 1, 2021, information described in such clause shall include Form CMS-2567 (or a successor form), along with such additional information determined appropriate by such body.

(B) Public disclosure of information

Beginning not later than October 1, 2022, the Secretary shall publish the information submitted under subparagraph (A) on the public website of the Centers for Medicare & Medicaid Services in a manner that is prominent, easily accessible, readily understandable, and searchable. The Secretary shall provide for the timely update of such information so published.

(3) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(4) Survey teams

(A) In general

In the case of a survey conducted under this subsection on or after October 1, 2021, by more than 1 individual, such survey shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(B) Prohibition of conflicts of interest

Beginning October 1, 2021, a State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the program surveyed respecting compliance with the requirements of section 1395x(dd) of this title or who has a personal or familial financial interest in the program being surveyed.

(C) Training

The Secretary shall provide, not later than October 1, 2021, for the comprehensive training of State and Federal surveyors, and any surveyor employed by a national accreditation body described in paragraph (2)(A)(i), in the conduct of surveys under this subsection, including training with respect to the review of written plans for providing hospice care (as described in section 1395f(a)(7)(B) of this title). No individual shall serve as a member of a survey team

with respect to a survey conducted on or after such date unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(5) Funding

The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $10,000,000 for each fiscal year (beginning with fiscal year 2022) for purposes of carrying out this subsection and subsection (b). Sums so transferred shall remain available until expended. Any transfer pursuant to this paragraph shall be in addition to any transfer pursuant to section 3(a)(2) of the Improving Medicare Post-Acute Care Transformation Act of 2014.

(b) Special focus program

(1) In general

The Secretary shall conduct a special focus program for enforcement of requirements for hospice programs that the Secretary has identified as having substantially failed to meet applicable requirements of this chapter.

(2) Periodic surveys

Under such special focus program, the Secretary shall conduct surveys of each hospice program in the special focus program not less than once every 6 months.

(c) Enforcement

(1) Situations involving immediate jeopardy

If the Secretary determines on the basis of a standard survey or otherwise that a hospice program that is certified for participation under this subchapter is no longer in compliance with the requirements specified in section 1395x(dd) of this title and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to ensure the removal of the jeopardy and correction of the deficiencies or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in paragraph (5)(B).

(2) Situations not involving immediate jeopardy

If the Secretary determines on the basis of a standard survey or otherwise that a hospice program that is certified for participation under this subchapter is no longer in compliance with the requirements specified in section 1395x(dd) of this title and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose remedies developed pursuant to paragraph (5)(A), in lieu of terminating the certification of the program. If, after such a period of remedies, the program is still no longer in compliance with such requirements, the Secretary shall terminate the certification of the program.

(3) Penalty for previous noncompliance

If the Secretary determines that a hospice program that is certified for participation under this subchapter is in compliance with the requirements specified in section 1395x(dd) of this title but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under paragraph (5)(B)(i) for the days in which the Secretary finds that the program was not in compliance with such requirements.

(4) Option to continue payments for noncompliant hospice programs

The Secretary may continue payments under this subchapter with respect to a hospice program not in compliance with the requirements specified in section 1395x(dd) of this title over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the program with such requirements than to terminate the certification of the program;

(B) the program has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action; and

(C) the program agrees to repay to the Federal Government payments received under this subchapter during such period if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by hospice programs under this paragraph.

(5) Remedies

(A) Development

(i) In general

Not later than October 1, 2022, the Secretary shall develop and implement—

(I) a range of remedies to apply to hospice programs under the conditions described in paragraphs (1) through (4); and

(II) appropriate procedures for appealing determinations relating to the imposition of such remedies.

Remedies developed pursuant to the preceding sentence shall include the remedies specified in subparagraph (B).

(ii) Conditions of imposition of remedies

Not later than October 1, 2022, the Secretary shall develop and implement specific procedures with respect to the conditions under which each of the remedies developed under clause (i) is to be applied, including the amount of any fines and the severity of each of these remedies. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(B) Specified remedies

The remedies specified in this subparagraph are the following:

(i) Civil money penalties in an amount not to exceed $10,000 for each day of noncompliance by a hospice program with the requirements specified in section 1395x(dd) of this title.

(ii) Suspension of all or part of the payments to which a hospice program would otherwise be entitled under this subchapter with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that remedies should be imposed pursuant to paragraphs (1) and (2).

(iii) The appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made in order to bring the program into compliance with all such requirements.

(C) Procedures

(i) Civil money penalties

(I) In general

Subject to subclause (II), the provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Retention of amounts for hospice program improvements

The Secretary may provide that any portion of civil money penalties collected under this subsection may be used to support activities that benefit individuals receiving hospice care, including education and training programs to ensure hospice program compliance with the requirements of section 1395x(dd) of this title.

(ii) Suspension of payment

A finding to suspend payment under subparagraph (B)(ii) shall terminate when the Secretary finds that the program is in substantial compliance with all requirements of section 1395x(dd) of this title.

(iii) Temporary management

The temporary management under subparagraph (B)(iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all the requirements referred to in such subparagraph.

(D) Relationship to other remedies

The remedies developed under subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(Aug. 14, 1935, ch. 531, title XVIII, § 1822, as added Pub. L. 116–260, div. CC, title IV, § 407(a)(1), Dec. 27, 2020, 134 Stat. 3003.)

Editorial Notes

REFERENCES IN TEXT

Section 3(a)(2) of the Improving Medicare Post-Acute Care Transformation Act of 2014, referred to in subsec. (a)(5), means section 3(a)(2) of Pub. L. 113–185, Oct. 6, 2014, 128 Stat. 1968, which is not classified to the Code.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395j. Establishment of supplementary medical insurance program for aged and disabled

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

(Aug. 14, 1935, ch. 531, title XVIII, § 1831, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 301; amended Pub. L. 92–603, title II, § 201(a)(3), Oct. 30, 1972, 86 Stat. 1371.)

Editorial Notes

AMENDMENTS

1972—Pub. L. 92–603 substituted ''aged and disabled individuals'' for ''individuals 65 years of age or over''.

Statutory Notes and Related Subsidiaries

STUDY REGARDING COVERAGE UNDER PART B OF MEDICARE FOR NONREIMBURSABLE SERVICES PROVIDED BY OPTOMETRISTS FOR PROSTHETIC LENSES FOR PATIENTS WITH APHAKIA

Pub. L. 94–182, title I, § 109, Dec. 31, 1975, 89 Stat. 1053, provided that the Secretary of Health, Education, and Welfare conduct a study on the appropriateness of reimbursement under the insurance program established by this part for services performed by optometrists with respect to the provision of prosthetic lenses for patients with aphakia and submit such study to Congress not later than 4 months after Dec. 31, 1975.

STUDY TO DETERMINE FEASIBILITY OF INCLUSION OF CERTAIN ADDITIONAL SERVICES UNDER PART B

Pub. L. 90–248, title I, § 141, Jan. 2, 1968, 81 Stat. 855, directed Secretary to conduct a study relating to inclusion under the supplementary medical insurance program under this part of services of additional types of licensed practitioners performing health services in independent practice and submit such study to Congress prior to Jan. 1, 1969.

§ 1395k. Scope of benefits; definitions

(a) Scope of benefits

The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2) and subparagraphs (E) and (F) of section 1395u(b)(6) of this title; and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1395x(b) of this title (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,

(ii) services for which payment may be made pursuant to section 1395n(b)(2) of this title,

(iii) services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;[1]

(iv) services of a nurse practitioner or clinical nurse specialist but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services; and[2]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1395x(p) of this title applies), outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1395x(g) of this title), and outpatient speech-language pathology services (other than services to which the second sentence of section 1395x(p) of this title applies through the application of section 1395x(*ll*)(2) of this title);

(D)(i) rural health clinic services and (ii) Federally qualified health center services;

(E) comprehensive outpatient rehabilitation facility services;

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

(i) pursuant to section 1395*l*(i)(1)(A) of this title and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the standard overhead amount determined under section 1395*l*(i)(2)(A) of this title as full payment for such services (including intraocular lens in cases described in section 1395*l*(i)(2)(A)(iii) of this title) and to accept an assignment described in section 1395u(b)(3)(B)(ii) of this title with respect to payment for all such services (including intraocular lens in cases described in section 1395*l*(i)(2)(A)(iii) of this title) furnished by the center to individuals enrolled under this part, or

(ii) pursuant to section 1395*l*(i)(1)(B) of this title and performed by a physician, described in paragraph (1), (2), or (3) of section 1395x(r) of this title, in his office, if the Secretary has determined that—

(I) a quality improvement organization (having a contract with the Secretary under part B of subchapter XI of this chapter) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

(II) the particular physician involved has agreed to make available to such organization such records as the Secretary determines to be necessary to carry out the review, and

(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the standard overhead amount determined under section 1395*l*(i)(2)(B) of this title as full payment for such services and to accept payment on an assignment-related basis with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1395x(s) of this title and furnished in connection with such surgical procedure to individuals enrolled under this part;

(G) covered items (described in section 1395m(a)(13) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services;

(H) outpatient critical access hospital services (as defined in section 1395x(mm)(3) of this title);

(I) prosthetic devices and orthotics and prosthetics (described in section 1395m(h)(4) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services; and

(J) partial hospitalization services provided by a community mental health center (as described in section 1395x(ff)(2)(B) of this title).

(b) Definitions

For definitions of ''spell of illness'', ''medical and other health services'', and other terms used in this part, see section 1395x of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1832, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 302; amended Pub. L. 90–248, title I, §§ 129(c)(6)(B), 133(d), Jan. 2, 1968, 81 Stat. 848, 851; Pub. L. 92–603, title II, §§ 227(e)(1), 251(a)(4), Oct. 30, 1972, 86 Stat. 1406, 1445; Pub. L. 95–210, § 1(a), Dec. 13, 1977, 91 Stat. 1485; Pub. L. 96–499, title IX, §§ 930(g), 933(a), 934(a), 948(a)(2), Dec. 5, 1980, 94 Stat. 2631, 2635, 2637, 2643; Pub. L. 97–248, title I, § 148(c), Sept. 3, 1982, 96 Stat. 394; Pub. L. 98–369, div. B, title III, §§ 2341(b), 2354(b)(6), July 18, 1984, 98 Stat. 1094, 1100; Pub. L. 99–509, title IX, §§ 9320(d), 9337(a), 9343(e)(1), Oct. 21, 1986, 100

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

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

Stat. 2013, 2033, 2041; Pub. L. 100–203, title IV, §§4062(d)(2), 4063(e)(2), 4073(b)(1), 4077(b)(2), 4085(i)(22)(A), Dec. 22, 1987, 101 Stat. 1330–108, 1330–118, 1330–120, as amended Pub. L. 100–360, title IV, §411(g)(2)(E), (h)(4)(A), (7)(B), (i)(4)(C)(vi), July 1, 1988, 102 Stat. 783, 786, 787, 789; Pub. L. 100–360, title I, §104(d)(3), title II, §§203(a), 205(a), July 1, 1988, 102 Stat. 689, 721, 729, 783; Pub. L. 101–234, title I, §101(a), title II, §201(a), Dec. 13, 1989, 103 Stat. 1979, 1981; Pub. L. 101–239, title VI, §6116(a)(2), Dec. 19, 1989, 103 Stat. 2219; Pub. L. 101–508, title IV, §§4153(a)(2)(A), 4155(b)(1), 4157(b), 4161(a)(3)(A), 4162(b)(1), Nov. 5, 1990, 104 Stat. 1388–83, 1388–86, 1388–89, 1388–93, 1388–96; Pub. L. 105–33, title IV, §§4201(c)(1), 4432(b)(5)(B), 4511(c), 4603(c)(2)(B)(ii), Aug. 5, 1997, 111 Stat. 373, 421, 443, 471; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–354; Pub. L. 106–554, §1(a)(6) [title I, §113(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473; Pub. L. 110–275, title I, §143(b)(1), July 15, 2008, 122 Stat. 2542; Pub. L. 112–40, title II, §261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423.)

Editorial Notes

AMENDMENTS

2011—Subsec. (a)(2)(F)(ii)(I). Pub. L. 112–40 substituted ''quality improvement'' for ''quality control and peer review''.

2008—Subsec. (a)(2)(C). Pub. L. 110–275 substituted '', outpatient'' for ''and outpatient'' and inserted '', and outpatient speech-language pathology services (other than services to which the second sentence of section 1395x(p) of this title applies through the application of section 1395x(*ll*)(2) of this title)'' before semicolon at end.

2000—Subsecs. (b), (c). Pub. L. 106–554 redesignated subsec. (c) as (b) and struck out former subsec. (b), which related to extension of coverage of immunosuppressive drugs for individuals who would exhaust benefits under section 1395x(s)(2)(J)(v) of this title in a year during the 5-year period beginning with 2000, and set forth provisions relating to extension periods for each year.

1999—Subsecs. (b), (c). Pub. L. 106–113 added subsec. (b) and redesignated former subsec. (b) as (c).

1997—Subsec. (a)(1). Pub. L. 105–33, §4603(c)(2)(B)(ii), substituted ''subparagraphs (E) and (F) of section 1395u(b)(6) of this title;'' for ''section 1395u(b)(6)(E) of this title;''.

Pub. L. 105–33, §4432(b)(5)(B), substituted ''(2) and section 1395u(b)(6)(E) of this title;'' for ''(2);''.

Subsec. (a)(2)(B)(iv). Pub. L. 105–33, §4511(c), substituted ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services'' for ''provided in a rural area (as defined in section 1395ww(d)(2)(D) of this title)''.

Subsec. (a)(2)(H). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

1990—Subsec. (a)(2)(A), (B). Pub. L. 101–508, §4153(a)(2)(A)(i), substituted ''subparagraph (G) or subparagraph (I)'' for ''subparagraph (G)''.

Subsec. (a)(2)(B)(iii). Pub. L. 101–508, §4157(b), amended cl. (iii) generally. Prior to amendment, cl. (iii) related to services of a certified registered nurse anesthetist.

Subsec. (a)(2)(B)(iv). Pub. L. 101–508, §4155(b)(1), added cl. (iv).

Subsec. (a)(2)(D). Pub. L. 101–508, §4161(a)(3)(A), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(I). Pub. L. 101–508, §4153(a)(2)(A)(ii)–(iv), added subpar. (I).

Subsec. (a)(2)(J). Pub. L. 101–508, §4162(b)(1), added subpar. (J).

1989—Subsec. (a). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§203(a), 205(a), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(2)(H). Pub. L. 101–239 added subpar. (H).

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

1988—Subsec. (a). Pub. L. 100–360, §205(a)(2), inserted sentence at end relating to in-home care provided to a chronically dependent individual on any day.

Subsec. (a)(2)(A). Pub. L. 100–360, §205(a)(1), designated existing provisions as cl. (i) and added cl. (ii) relating to in-home care for a chronically dependent individual.

Pub. L. 100–360, §203(a), inserted ''and home intravenous drug therapy services'' before semicolon at end.

Subsec. (a)(2)(B)(iv). Pub. L. 100–360, §411(h)(7)(B), struck out Pub. L. 100–203, §4077(b)(2), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(A), struck out Pub. L. 100–203, §4073(b)(1), see 1987 Amendment note below.

Subsec. (a)(2)(F)(i). Pub. L. 100–360, §411(g)(2)(E), added Pub. L. 100–203, §4063(e)(2), see 1987 Amendment note below.

Subsec. (a)(2)(F)(ii). Pub. L. 100–360, §411(i)(4) (C)(vi), added Pub. L. 100–203, §4085(i)(22)(A), see 1987 Amendment note below.

Subsec. (b). Pub. L. 100–360, §104(d)(3), substituted ''definitions of 'medical and other health services' and'' for ''definitions of 'spell of illness', 'medical and other health services', and''.

1987—Subsec. (a)(2)(A). Pub. L. 100–203, §4062(d)(2)(A), inserted ''(other than items described in subparagraph (G))'' after ''services''.

Subsec. (a)(2)(B). Pub. L. 100–203, §4062(d)(2)(B), inserted ''(other than items described in subparagraph (G))'' after ''health services''.

Subsec. (a)(2)(B)(iv). Pub. L. 100–203, §4077(b)(2), which directed the addition of cl. (iv) relating to qualified psychologist services, was repealed by Pub. L. 100–360, §411(h)(7)(B).

Pub. L. 100–203, §4073(b)(1), which directed the addition of cl. (iv) relating to certified nurse-midwife services, was repealed by Pub. L. 100–360, §411(h)(4)(A).

Subsec. (a)(2)(F)(i). Pub. L. 100–203, §4063(e)(2), as added by Pub. L. 100–360, §411(g)(2)(E), inserted ''(including intraocular lens in cases described in section 1395*l*(i)(2)(A)(iii) of this title)'' after ''services'' in two places.

Subsec. (a)(2)(F)(ii). Pub. L. 100–203, §4085(i)(22)(A), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted ''payment on an assignment-related basis'' for ''an assignment described in section 1395u(b)(3)(B)(ii) of this title'' in concluding provisions.

Subsec. (a)(2)(G). Pub. L. 100–203, §4062(d)(2)(C), added subpar. (G).

1986—Subsec. (a)(2)(B)(iii). Pub. L. 99–509, §9320(d), added cl. (iii).

Subsec. (a)(2)(C). Pub. L. 99–509, §9337(a), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''outpatient physical therapy services, other than services to which the next to last sentence of section 1395x(p) of this title applies;''.

Subsec. (a)(2)(F). Pub. L. 99–509, §9343(e)(1), inserted ''standard overhead'' in cl. (i) and concluding provisions of cl. (ii).

1984—Subsec. (a)(2)(F)(ii). Pub. L. 98–369, §2341(b), substituted ''paragraph (1), (2), or (3) of section 1395x(r) of this title'' for ''section 1395x(r)(1) of this title''.

Subsec. (a)(2)(F)(ii)(II). Pub. L. 98–369, §2354(b)(6), substituted ''organization'' for ''Organization''.

1982—Subsec. (a)(2)(F)(ii)(I). Pub. L. 97–248 substituted ''quality control and peer review organization (having a contract with the Secretary'' for ''Professional Standards Review Organization (designated, conditionally or otherwise,''.

1980—Subsec. (a)(2)(A). Pub. L. 96–499, §930(g), struck out restriction on home health services of 100 visits during a calendar year.

Subsec. (a)(2)(B)(i)(II). Pub. L. 96–499, §948(a)(2), substituted ''where the conditions specified in paragraph (7) of such section are met'' for '', unless either clause (A) or (B) of paragraph (7) of such section is met''.

Subsec. (a)(2)(E). Pub. L. 96–499, §933(a), added subpar. (E).

Subsec. (a)(2)(F). Pub. L. 96–499, §934(a), added subpar. (F).

1977—Subsec. (a)(1). Pub. L. 95–210, §1(a)(1), substituted ''subparagraphs (B) and (D) of paragraph (2)'' for ''paragraph (2)(B)''.

Subsec. (a)(2)(D). Pub. L. 95–210, §1(a)(2), added subpar. (D).

1972—Subsec. (a)(2)(B). Pub. L. 92–603, §227(e)(1), inserted provisions relating to medical and other health services performed by a physician to a patient in a hospital which has an approved teaching program.

Subsec. (a)(2)(C). Pub. L. 92–603, §251(a)(4), inserted '', other than services to which the next to last sentence of section 1395x(p) of this title applies''.

1968—Subsec. (a)(2)(B). Pub. L. 90–248, §129(c)(6)(B), inserted ''and the services for which payment may be made pursuant to section 1395n(b)(2) of this title'' after ''hospital''.

Subsec. (a)(2)(C). Pub. L. 90–248, §133(d), added subpar. (C).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

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

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §143(c), July 15, 2008, 122 Stat. 2543, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395n, 1395x, 1395y, 1395cc, and 1395nn of this title] shall apply to services furnished on or after July 1, 2009.''

EFFECTIVE DATE OF 1997 AMENDMENT

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

Amendment by section 4432(b)(5)(B) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Pub. L. 105–33, title IV, §4511(e), Aug. 5, 1997, 111 Stat. 443, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395x, 1395y, 1395cc, and 1395yy of this title] shall apply with respect to services furnished and supplies provided on and after January 1, 1998.''

Amendment by section 4603(c)(2)(B)(ii) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4153(a)(3), Nov. 5, 1990, 104 Stat. 1388–83, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and sections 1395*l* and 1395m of this title] shall apply to items furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4155(e), Nov. 5, 1990, 104 Stat. 1388–88, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395u, and 1395x of this title] shall apply to services furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4157(d), Nov. 5, 1990, 104 Stat. 1388–89, provided that: ''The amendments made by the preceding subsections [amending this section and sections 1395x, 1395y, and 1395cc of this title] apply to services furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4161(a)(8), Nov. 5, 1990, 104 Stat. 1388–95, provided that:

''(A) Subject to subparagraphs (B) and (C), the amendments made by this section [probably means this subsection, which amended this section and sections 1320a–7b, 1395*l*, 1395x, 1395y, and 1395*oo* of this title] shall apply to services furnished on or after October 1, 1991.

''(B) In the case of a Federally qualified health care center that has elected, as of January 1, 1990, under part B of title XVIII of the Social Security Act [this part], to have the amount of payments for services under such part determined on a reasonable-charge basis, the amendment made by paragraph (3)(A) [amending this section] shall only apply on and after such date (not earlier than October 1, 1991) as the center may elect.

''(C) The amendment made by paragraph (6) [amending section 1395*oo* of this title] shall apply to cost reports for periods beginning on or after October 1, 1991.''

Pub. L. 101–508, title IV, §4162(c), Nov. 5, 1990, 104 Stat. 1388–96, provided that: ''The amendments made by subsections (a) and (b) [amending this section and sections 1395x and 1395cc of this title] shall apply with respect to partial hospitalization services provided on or after October 1, 1991.''

EFFECTIVE DATE OF 1989 AMENDMENT

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

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 104(d)(3) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 203(a) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Pub. L. 100–360, title II, §205(f), July 1, 1988, 102 Stat. 731, which provided that the amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395*l*, 1395n, 1395x, and 1395y of this title] were applicable to items and services furnished on or after January 1, 1990, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(g)(2)(E), (h)(4)(A), (7)(B), (i)(4)(C)(vi) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4062(d)(2) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4073(e), Dec. 22, 1987, 101 Stat. 1330–119, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395x, and 1396d of this title] shall be effective with respect to services performed on or after July 1, 1988.''

Pub. L. 100–203, title IV, §4077(b)(5), formerly §4077(b)(6), Dec. 22, 1987, 101 Stat. 1330–121, as renumbered by Pub. L. 100–360, title IV, §411(h)(7)(F), July 1, 1988, 102 Stat. 787, provided that: ''The amendments made by this subsection [amending this section and sections 1395*l* and 1395x of this title] shall be effective with respect to services performed on or after July 1, 1988.''

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9320(i), Oct. 21, 1986, 100 Stat. 2016, as amended by Pub. L. 100–485, title VI, §608(c)(1), Oct. 13, 1988, 102 Stat. 2412, provided that: ''Except as provided in subsection (k) [set out below], the amendments made by this section (other than subsection (a)) [amending this section and sections 1395*l*, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title] shall apply to services furnished on or after January 1, 1989.''

Pub. L. 99–509, title IX, §9337(e), Oct. 21, 1986, 100 Stat. 2034, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395n, 1395x, and 1395cc of this title] shall apply to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987.''

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2341(d), July 18, 1984, 98 Stat. 1094, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] apply to services furnished on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(6) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

Pub. L. 96–499, title IX, §933(h), Dec. 5, 1980, 94 Stat. 2637, provided that: ''The amendments made by this section [amending this section and sections 1395n, 1395x, 1395z, and 1395aa of this title] shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981.''

Amendment by section 948(a)(2) of Pub. L. 96–499 applicable with respect to cost accounting periods beginning on or after Oct. 1, 1978, see section 948(c)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–210, §1(j), Dec. 13, 1977, 91 Stat. 1488, provided that: ''The amendments made by this section [amending this section and sections 1395*l*, 1395x, 1395y, and 1395aa of this title and enacting provisions set out as notes under sections 1395*l* and 1395x of this title] shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act [Dec. 13, 1977].''

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 227(e)(1) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 251(a)(4) of Pub. L. 92–603 applicable with respect to services furnished on or after July 1, 1973, see section 251(d)(1) of Pub. L. 92–603, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(6)(B) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §133(g), Jan. 2, 1968, 81 Stat. 852, provided that: ''The amendments made by the preceding subsections of this section [amending this section and sections 1395n, 1395x, 1395aa, and 1395cc of this title] shall apply to services furnished after June 30, 1968.''

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §143(d), July 15, 2008, 122 Stat. 2543, provided that: ''Nothing in this section [amending this section and sections 1395*l*, 1395n, 1395x, 1395y, 1395cc, and 1395nn of this title] shall be construed to affect existing regulations and policies of the Centers for Medicare & Medicaid Services that require physician oversight of care as a condition of payment for speech-language pathology services under part B of the Medicare program [42 U.S.C. 1395j et seq.].''

CONSTRUCTION OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9320(j), Oct. 21, 1986, 100 Stat. 2016, provided that: ''Nothing in this section or the amendments made by this section [amending this section and sections 1395*l*, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title, enacting provisions set out as notes under this section, and amending provisions set out as a note under section 1395ww of this title] shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.''

REPORT ON IMMUNOSUPPRESSIVE DRUG BENEFIT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, which required the Secretary of Health and Human Services to submit to Congress not later than Mar. 1, 2003, a report on the operation of section 1000(a)(6) [title II, §227] of Pub. L. 106–113, amending this section and section 1395x of this title, including an analysis of impact and recommendations regarding an appropriate cost-effective method for providing coverage of immunosuppressive drugs under the medicare program on a permanent basis, was repealed by Pub. L. 106–554, §1(a)(6) [title I, §113(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473.

QUALITY AND UTILIZATION OF IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUALS

Pub. L. 100–360, title II, §205(e)(2), July 1, 1988, 102 Stat. 731, directed Secretary of Health and Human Services to take appropriate efforts to assure quality and provide for appropriate utilization of in-home care for chronically dependent individuals under the amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395*l*, 1395n, 1395x, and 1395y of this title], prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES

Pub. L. 100–360, title II, §205(g), July 1, 1988, 102 Stat. 731, which required Secretary of Health and Human Services to study, and report to Congress, not later than 18 months after July 1, 1988, on advisability of providing, to chronically dependent individuals eligible for in-home care under amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395*l*, 1395n, 1395x, and 1395y of this title], out-of-home services as alternative services to in-home care, was re-

pealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

CONTINUATION OF COST PASS-THROUGH FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

Pub. L. 99–509, title IX, §9320(k), as added by Pub. L. 100–485, title VI, §608(c)(2), Oct. 13, 1988, 102 Stat. 2412, and amended by Pub. L. 101–239, title VI, §6132(a), Dec. 19, 1989, 103 Stat. 2222, provided that:

''(1) Subject to paragraph (2), the amendments made by this section [amending this section and sections 1395*l*, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title and provisions set out as a note under section 1395ww of this title] shall not apply during a year (beginning with 1989) to a hospital located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)]) if the hospital establishes, at any time before the year[,] to the satisfaction of the Secretary of Health and Human Services that—

''(A) as of January 1, 1988, the hospital employed or contracted with a certified registered nurse anesthetist (but not more than one full-time equivalent certified registered nurse anesthetist),

''(B) in 1987 the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 500 (or such higher number as the Secretary determines to be appropriate), and

''(C) each certified registered nurse anesthetist employed by, or under contract with, the hospital has agreed not to bill under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for professional services furnished by the anesthetist at the hospital.

''(2) Paragraph (1) shall not apply in a year (after 1989) to a hospital unless the hospital establishes, before the beginning of the year, that the hospital has had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services in the previous year that did not exceed 500 (or such higher number as the Secretary determines to be appropriate).''

[Pub. L. 101–239, title VI, §6132(b), Dec. 19, 1989, 103 Stat. 2222, provided that: ''The amendments made by this section [amending section 9320(k) of Pub. L. 99–509, set out above] shall apply to services furnished on or after January 1, 1990.'']

PAYMENT FOR SERVICES OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL FOR ACCOUNTING PERIODS BEGINNING AFTER JUNE 30, 1975, AND PRIOR TO OCTOBER 1, 1978; STUDIES, REPORTS, ETC.; EFFECTIVE DATES

Pub. L. 93–233, §15(a)(2), Dec. 31, 1973, 87 Stat. 966, provided that for the cost accounting periods beginning after June 30, 1975, and prior to Oct. 1, 1978, subsec. (a)(2)(B)(i) of this section will be administered as if subclause II of subsec. (a)(2)(B)(i) read as follows: ''(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) [42 U.S.C. 1395x(b)(6)] (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section [42 U.S.C. 1395x(b)(7)] are met and''.

§ 1395*l*. Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k(a)(1) of this title—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1395x(s)(10)(A) of this title, the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1395y(a)(4) of this title, the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule under subsection (h)(1) (for tests furnished before January 1, 2017) or section 1395m(d)(1) of this title, the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,,[1] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1395rr of this title, (F) with respect to clinical social worker services under section 1395x(s)(2)(N) of this title, the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a re-

[1] So in original.

vised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system, (H) with respect to services of a certified registered nurse anesthetist under section 1395x(s)(11) of this title, the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (*l*), (I) with respect to covered items (described in section 1395m(a)(13) of this title), the amounts paid shall be the amounts described in section 1395m(a)(1) of this title, and[2] (J) with respect to expenses incurred for radiologist services (as defined in section 1395m(b)(6) of this title), subject to section 1395w–4 of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1395m(b) of this title, (K) with respect to certified nurse-midwife services under section 1395x(s)(2)(L) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1395w–4 of this title for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1395x(s)(2)(M) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1395m(h)(4) of this title), the amounts paid shall be the amounts described in section 1395m(h)(1) of this title, (N) with respect to expenses incurred for physicians' services (as defined in section 1395w–4(j)(3) of this title) other than personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), the amounts paid shall be 80 percent of the payment basis determined under section 1395w–4(a)(1) of this title, (O) with respect to services described in section 1395x(s)(2)(K) of this title (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1395w–4 of this title, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1395m(i) of this title, (Q) with respect to items or services for which fee schedules are established pursuant to section 1395u(s) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1395m(*l*) of this title and (ii) with respect to ambulance services described in section 1395m(*l*)(8) of this title, the amounts paid shall be the amounts determined under section 1395m(g) of this title for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1395x(zz) of this title)) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1395u(*o*) of this title (or, if applicable, under section 1395w–3, 1395w–3a, or 1395w–3b of this title), (T) with respect to medical nutrition therapy services (as defined in section 1395x(vv) of this title), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1395w–4(b) of this title for the same services if furnished by a physician, (U) with respect to facility fees described in section 1395m(m)(2)(B) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1395u(s) items), with respect to competitively priced items and services (described in section 1395w–3(a)(2) of this title) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1395w–3(b)(5) of this title, (W) with respect to additional preventive services (as defined in section 1395x(ddd)(1) of this title), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting ''100 percent'' for ''80 percent''), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a

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

fee schedule established by the Secretary for purposes of this subparagraph, (X) with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1395w–4 of this title, (Y) subject to subsection (dd), with respect to preventive services described in subparagraphs (A) and (B) of section 1395x(ddd)(3) of this title that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), (Z) with respect to Federally qualified health center services for which payment is made under section 1395m(*o*) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section, (AA) with respect to an applicable disposable device (as defined in paragraph (2) of section 1395m(s) of this title) furnished to an individual pursuant to paragraph (1) of such section, the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under paragraph (3) of such section, (BB) with respect to home infusion therapy, the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under section 1395m(u) of this title, (CC) with respect to opioid use disorder treatment services furnished during an episode of care, the amount paid shall be equal to the amount payable under section 1395m(w) of this title less any copayment required as specified by the Secretary, and (DD) with respect to a specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection, the amounts paid shall be 100 percent of the payment amount otherwise recognized under such respective specified outpatient payment provision for such service,;[1]

(2) in the case of services described in section 1395k(a)(2) of this title (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1395rr of this title)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1395x(kk) of this title), the amount determined under the prospective payment system under section 1395fff of this title;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1395ww of this title or section 1395yy(e)(9) of this title)—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

(II) the customary charges with respect to such services,

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

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1395f(b)(2) of this title, or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1395f(b)(3) of this title are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1395x(p) of this title, 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule determined under subsection (h)(1) (for tests furnished before January 1, 2017) or section 1395m(d)(1) of this title, the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1395cc of this title) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1395cc of this title) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography and, for services furnished on or after January 1, 2005, diagnostic mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1395x(s)(3) of this title (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1395x(kk) of this title) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1395x(v) of this title;

(G) with respect to items and services described in section 1395x(s)(10)(A) of this title, the lesser of—

(i) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

(ii) the customary charges with respect to such services; and

(H) with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),

or,[3] if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title;

(3) in the case of services described in section 1395k(a)(2)(D) of this title—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1395x(v)(1)(A) of this title, less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title, but in no case may the payment for such services (other than for items and services described in section 1395x(s)(10)(A) of this title) exceed 80 percent of such costs; or

(B) with respect to the services described in clause (ii) of section 1395k(a)(2)(D) of this title that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1395w–23(a)(4) of this title, the amount (if any) by which—

(i) the amount of payment that would have otherwise been provided (I) under subparagraph (A) (calculated as if ''100 percent'' were substituted for ''80 percent'' in such subparagraph) for such services if the individual had not been so enrolled, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1395m(*o*) of this title, under such section (calculated as if ''100 percent'' were substituted for ''80 percent'' in such section) for such services if the individual had not been so enrolled; exceeds

(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the federally qualified health center may charge as described in section 1395w–27(e)(3)(B) of this title;

(4) in the case of facility services described in section 1395k(a)(2)(F) of this title, and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to subsection (i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1395m(a)(13) of this title) the amounts described in section 1395m(a)(1) of this title;

(6) in the case of outpatient critical access hospital services, the amounts described in section 1395m(g) of this title;

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1395m(h)(4) of this title), the amounts described in section 1395m(h) of this title;

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1395m(k) of this title;

[3] See 2010 Amendment note for subsec. (a)(2)(F) to (H) below.

(9) in the case of services described in section 1395k(a)(2)(E) of this title that are not described in paragraph (8), the amounts described in section 1395m(k) of this title; and

(10) with respect to rural emergency hospital services furnished on or after January 1, 2023, the amounts determined under section 1395m(x) of this title.

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1395m(*o*) of this title. For services furnished on or after January 1, 2022, paragraph (1)(Y) shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(b) Deductible provision

Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1395r(a)(1) of this title ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1395x(ddd)(3) of this title that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.,[1] (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title)), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1395cc of this title, or (B) for tests furnished before January 1, 2017, on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1395x(jj) of this title), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1395x(nn) of this title), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1395x(bbb) of this title), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1395x(pp)(1) of this title), (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1395x(ww) of this title), (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), (11) such deductible shall not apply with respect to any specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection, and (12) such deductible shall not apply with respect[4] a COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1395e(a)(2) of this title to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(c) Mental disorders

(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

(C) for expenses incurred in 2012, only 75 percent of such expenses;

[4] So in original. Probably should be followed by ''to''.

(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term ''treatment'' does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.

(d) Nonduplication of payments

No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1395e of this title) to have payment made with respect to such services under part A.

(e) Information for determination of amounts due

No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) Maximum rate of payment per visit for independent rural health clinics

(1) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided prior to April 1, 2021—

(A) in 1988, after March 31, at $46 per visit, and

(B) in a subsequent year (before April 1, 2021), at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) furnished as of the first day of that year.

(2) In establishing limits under subsection (a) on payment for rural health clinic services furnished on or after April 1, 2021, by a rural health clinic (other than a rural health clinic described in paragraph (3)(B)), the Secretary shall establish such limit, for services provided—

(A) in 2021, after March 31, at $100 per visit;

(B) in 2022, at $113 per visit;

(C) in 2023, at $126 per visit;

(D) in 2024, at $139 per visit;

(E) in 2025, at $152 per visit;

(F) in 2026, at $165 per visit;

(G) in 2027, at $178 per visit;

(H) in 2028, at $190 per visit; and

(I) in a subsequent year, at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year.

(3)(A) In establishing limits under subsection (a) on payment for rural health clinic services furnished on or after April 1, 2021, by a rural health clinic described in subparagraph (B), the Secretary shall establish such limit, with respect to each such rural health clinic, for services provided—

(i) in 2021, after March 31, at an amount equal to the greater of—

(I) with respect to a rural health clinic that had a per visit payment amount established for services furnished in 2020—

(aa) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or

(bb) the limit described in paragraph (2)(A); and

(II) with respect to a rural health clinic that did not have a per visit payment amount established for services furnished in 2020—

(aa) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2021; or

(bb) the limit described in paragraph (2)(A); and

(ii) in a subsequent year, at an amount equal to the greater of—

(I) the amount established under subclause (I) or (II) of clause (i), as applicable, or this subclause for the previous year with respect to such rural health clinic, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year; or

(II) the limit established under paragraph (2) for such subsequent year.

(B) A rural health clinic described in this subparagraph is a rural health clinic that—

(i) as of December 31, 2020, was in a hospital with less than 50 beds and after such date such hospital continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver under subsection (b)(1)(A) of section 1320b–5 of this title during the emergency period described in subsection (g)(1)(B) of such section); and

(ii)(I) as of December 31, 2020, was enrolled under section 1395cc(j) of this title (including temporary enrollment during such emergency period for such emergency period); or

(II) submitted an application for enrollment under section 1395cc(j) of this title (or a request for such a temporary enrollment for such emergency period) that was received not later than December 31, 2020.

(g) Physical therapy services

(1)(A) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1395x(p) of this title and speech-language pathology services of the type described in such section through the application of section 1395x(*ll*)(2) of this title, but (except as provided in paragraph (6)) not described in subsection (a)(8)(B), and physical therapy services and speech-language pathology services

of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of physical therapy services of the type described in section 1395x(p) of this title, speech-language pathology services of the type described in such section through the application of section 1395x(*ll*)(2) of this title, and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3)(A) Subject to paragraphs (4) and (5), in the case of occupational therapy services (of the type that are described in section 1395x(p) of this title (but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)) through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of occupational therapy services (of the type that are described in section 1395x(p) of this title through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005.

(5)(A) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2017, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary and if the requirement of subparagraph (B) is met. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request made in accordance with such requirement, the Secretary shall be deemed to have found the services to be medically necessary.

(B) In the case of outpatient therapy services for which an exception is requested under the first sentence of subparagraph (A), the claim for such services shall contain an appropriate modifier (such as the KX modifier used as of February 22, 2012) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(C)(i) In applying this paragraph with respect to a request for an exception with respect to expenses that would be incurred for outpatient therapy services (including services described in subsection (a)(8)(B)) that would exceed the threshold described in clause (ii) for a year, the request for such an exception, for services furnished on or after October 1, 2012, shall be subject to a manual medical review process that, subject to subparagraph (E), is similar to the manual medical review process used for certain exceptions under this paragraph in 2006.

(ii) The threshold under this clause for a year is $3,700. Such threshold shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(E)(i)[5] In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a ''therapy provider'') using such factors as the Secretary determines to be appropriate.

(ii) Such factors may include the following:

(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this subchapter.

(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

(III) The therapy provider is newly enrolled under this subchapter or has not previously furnished therapy services under this part.

(IV) The services are furnished to treat a type of medical condition.

(V) The therapy provider is part of group[6] that includes another therapy provider identi-

[5] So in original. There is no subpar. (D).

[6] So in original. Probably should be preceded by ''a''.

fied using the factors determined under this subparagraph.

(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor under section 1395ddd(h) of this title for medical reviews under this subparagraph.

(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented, except as such process is applied under paragraph (7)(B).

(6)(A) In applying paragraphs (1) and (3) to services furnished during the period beginning not later than October 1, 2012, and ending on December 31, 2017, the exclusion of services described in subsection (a)(8)(B) from the uniform dollar limitation specified in paragraph (2) shall not apply to such services furnished during 2012 through 2017.

(B)(i) With respect to outpatient therapy services furnished beginning on or after January 1, 2013, and before January 1, 2014, for which payment is made under section 1395m(g) of this title, the Secretary shall count toward the uniform dollar limitations described in paragraphs (1) and (3) and the threshold described in paragraph (5)(C) the amount that would be payable under this part if such services were paid under section 1395m(k)(1)(B) of this title instead of being paid under section 1395m(g) of this title.

(ii) Nothing in clause (i) shall be construed as changing the method of payment for outpatient therapy services under section 1395m(g) of this title.

(7) For purposes of paragraphs (1)(B) and (3)(B), with respect to services described in such paragraphs, the requirements described in this paragraph are as follows:

(A) Inclusion of appropriate modifier

The claim for such services contains an appropriate modifier (such as the KX modifier described in paragraph (5)(B)) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(B) Targeted medical review for certain services above threshold

(i) In general

In the case where expenses that would be incurred for such services would exceed the threshold described in clause (ii) for the year, such services shall be subject to the process for medical review implemented under paragraph (5)(E).

(ii) Threshold

The threshold under this clause for—

(I) a year before 2028, is $3,000;

(II) 2028, is the amount specified in subclause (I) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for 2028; and

(III) a subsequent year, is the amount specified in this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year;

except that if an increase under subclause (II) or (III) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(iii) Application

The threshold under clause (ii) shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(iv) Funding

For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000 for each fiscal year beginning with fiscal year 2018, to remain available until expended. Such funds may not be used by a contractor under section 1395ddd(h) of this title for medical reviews under this subparagraph.

(8) With respect to services furnished on or after January 1, 2013, where payment may not be made as a result of application of paragraphs (1) and (3), section 1395pp of this title shall apply in the same manner as such section applies to a denial that is made by reason of section 1395y(a)(1) of this title.

(h) Fee schedules for clinical diagnostic laboratory tests; percentage of prevailing charge level; nominal fee for samples; adjustments; recipients of payments; negotiated payment rate

(1)(A) Subject to section 1395m(d)(1) of this title, the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1395x(*oo*) of this title consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(D) In this subsection, the term ''qualified hospital laboratory'' means a hospital laboratory, in a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in clause (v), subparagraph (B), and paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1395u(b)(3) of this title for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 and 2010, 0.5 percentage points, and, for tests furnished before April 1, 2014, subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1395u(b)(3) of this title performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(v) The Secretary shall reduce by 2 percent the fee schedules otherwise determined under clause (i) for 2013, and such reduced fee schedules shall serve as the base for 2014 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017) or under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this subchapter for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical

diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1395cc of this title, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)),[7] receives requests for testing during the year in which the test is performed[7] are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1395x(w)(1) of this title) made by a hospital, critical access hospital, or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1395cc of this title.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1395u(j) of this title in the same manner such paragraphs apply[8] with respect to a physician. Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(6) For tests furnished before January 1, 2017, in the case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4) and section 1395m–1 of this title, the Secretary shall establish a national minimum payment amount under this part for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

---

[7] So in original. The comma after ''subclause (II))'' probably should follow ''is performed''.

[8] So in original. Probably should be ''such paragraph applies''.

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as ''new tests'').

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term ''HCPCS'' refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be ''substantially revised'' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).

(i) Outpatient surgery

(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1395k(a)(2)(F)(i) of this title), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years, in consultation with appropriate trade and professional organizations.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), subject to subparagraph (E), the amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this subchapter than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and re-

lated to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this subchapter than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).

(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

(vi) There shall be no administrative or judicial review under section 1395ff, 1395*oo* of this title, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of subsection (t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such subsection,

the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory

surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title.

(ii) Subject to paragraph (4), in this paragraph:

(I) The term ''cost proportion'' means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term ''ASC proportion'' means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this[9] subparagraph (A)(iii)(II), the term ''eye or eye and ear unit'' means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1395k(a)(2)(F)(i) of this title, who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing any annual increase factor for a subsequent year.

(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of subsection (t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(8) The Secretary shall conduct a similar type of review as required under paragraph (22) of section 1395*l*(t) of this title),[10] including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection, and make such revisions under this paragraph, in an appropriate manner (as determined by the Secretary).

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

Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title was in excess of or less than the amount of payment that is due,

[9] So in original. The word ''this'' probably should not appear.

[10] So in original. The closing parenthesis preceding the comma probably should not appear.

and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments (or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation), at a rate of 4 percent).

(k) Hepatitis B vaccine

With respect to services described in section 1395x(s)(10)(B) of this title, the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(*l*) Fee schedule for services of certified registered nurse anesthetists

(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1395x(s)(11) of this title.

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this subchapter for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this subchapter for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this subchapter plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1395u(b)(3) of this title.

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1395w–4(d) of this title for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1395w–4 of this title (or, in the case of services furnished during 1991, the localities used under section 1395u(b) of this title) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—[11]

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1395u(q)(1)(B) of this title for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1395w–4 of this title,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1395w–4 of this title).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

[11] So in original. Probably should be ''are—''.

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75, and

(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1395w–4(a)(5)(B) of this title with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs[12] (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this subchapter.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1395u(j)(1)(D) of this title.

(m) Incentive payments for physicians' services furnished in underserved areas

(1) In the case of physicians' services furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 254e(a)(1)(A) of this title) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

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

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n) Payments to hospital outpatient departments for radiology; amount; definitions

(1)(A)[13] The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services de-

[12] So in original. Probably should be ''subparagraph''.

[13] So in original. No par. (2) has been enacted.

scribed in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after April 1, 1989 and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1395u(b) of this title (or, in the case of services furnished on or after January 1, 1992, under section 1395w–4 of this title), less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title.

(ii) In this subparagraph:

(I) The term ''cost proportion'' means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term ''charge proportion'' means 100 percent minus the cost proportion.

(*o*) Limitation on benefit for payment for therapeutic shoes for individuals with severe diabetic foot disease

(1) In the case of shoes described in section 1395x(s)(12) of this title—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1395m(h) of this title.

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1395m(h) of this title if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1395x(s)(12) of this title may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1395m(h) of this title, a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this subchapter, the term ''shoes'' includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

(p) Repealed. Pub. L. 103–432, title I, § 123(b)(2)(A)(ii), Oct. 31, 1994, 108 Stat. 4411

(q) Requests for payment to include information on referring physician

(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1395nn of this title) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this chapter for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1320a–7 of this title.

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

(r) Cap on prevailing charge; billing on assignment-related basis

(1) With respect to services described in section 1395x(s)(2)(K)(ii) of this title (relating to

nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1396r(a) of this title), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1395x(s)(2)(K)(ii) of this title may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this subchapter.

(s) Other prepaid organizations

The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(t) Prospective payment system for hospital outpatient department services

(1) Amount of payment

(A) In general

With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) Definition of covered OPD services

For purposes of this subsection, the term ''covered OPD services''—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1395x(s) of this title;

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1395m(k) of this title or section 1395m(*l*) of this title and does not include screening mammography (as defined in section 1395x(jj) of this title), diagnostic mammography, or personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title); and

(v) does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(2) System requirements

Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Secretary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and

(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices and for stranded and non-stranded devices furnished on or after July 1, 2007.

For purposes of subparagraph (B), items and services within a group shall not be treated as ''comparable with respect to the use of resources'' if the highest median cost (or mean cost, if elected by the Secretary under sub-

paragraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 360bb of title 21.

(3) Calculation of base amounts

(A) Aggregate amounts that would be payable if deductibles were disregarded

The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under subsection (b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under subsection (b) did not apply.

(B) Unadjusted copayment amount

(i) In general

For purposes of this subsection, subject to clause (ii), the ''unadjusted copayment amount'' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) Adjusted to be 20 percent when fully phased in

If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) Rules for new services

The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

(C) Calculation of conversion factors

(i) For 1999

(I) In general

The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) Product described

The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) Subsequent years

Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv) for the year involved.

(iii) Adjustment for service mix changes

Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD fee schedule increase factor

For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the ''OPD fee schedule increase factor'' for services furnished in a year is equal to the market basket percentage increase applicable under section 1395ww(b)(3)(B)(iii) of this title to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) Calculation of medicare OPD fee schedule amounts

The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) Pre-deductible payment percentage

The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(F) Productivity and other adjustment

After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) Other adjustment

For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point;

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

(4) Medicare payment amount

The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7), as follows:

(A) Fee schedule adjustments

The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) Subtract applicable deductible

Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under subsection (b), to the extent applicable.

(C) Apply payment proportion to remainder

The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) Outlier adjustment

(A) In general

Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) Amount of adjustment

The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) Limit on aggregate outlier adjustments

(i) In general

The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) Applicable percentage

For purposes of clause (i), the term ''applicable percentage'' means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) Transitional authority

In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E) Exclusion of separate drug and biological APCS from outlier payments

No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) Transitional pass-through for additional costs of innovative medical devices, drugs, and biologicals

(A) In general

The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) Current orphan drugs

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 360bb of title 21 if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) Current cancer therapy drugs and biologicals and brachytherapy

A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature monitored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) Current radiopharmaceutical drugs and biological products

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) New medical devices, drugs, and biologicals

A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) Use of categories in determining eligibility of a device for pass-through payments

The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) Establishment of initial categories

(I) In general

The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) Authorization of implementation other than through regulations

The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) Establishing criteria for additional categories

(I) In general

The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) Standard

Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) Deadline

Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

(IV) Adding categories

The Secretary shall promptly establish a new category of medical devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) Period for which category is in effect

A category of medical devices established under clause (i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) Requirements treated as met

A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 360e of title 21 has been approved with respect to the device, or the device has been cleared for market under section 360(k) of title 21, or the device is exempt from the requirements of section 360(k) of title 21 pursuant to subsection (*l*) or (m) of section 360 of title 21 or section 360j(g) of title 21.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) Limited period of payment

(i) Drugs and biologicals

Subject to subparagraph (G), the payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) Medical devices

Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) Amount of additional payment

Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) subject to subparagraph (H), in the case of a drug or biological, the amount by which the amount determined under section 1395u(*o*) of this title (or if the drug or biological is covered under a competitive acquisition contract under section 1395w–3b of this title, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) Limit on aggregate annual adjustment

(i) In general

The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year. This clause shall not apply for 2018 or 2020.

(ii) Applicable percentage

For purposes of clause (i), the term ''applicable percentage'' means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) Uniform prospective reduction if aggregate limit projected to be exceeded

If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in

order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F) Limitation of application of functional equivalence standard

(i) In general

The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) Application

Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after December 8, 2003, unless—

(I) such application was being made to such drug or biological prior to December 8, 2003; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this subchapter.

(iii) Rule of construction

Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(G) Pass-through extension for certain drugs and biologicals

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, such pass-through status shall be extended for a 2-year period beginning on October 1, 2018.

(H) Temporary payment rule for certain drugs and biologicals

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, the payment amount for such drug or biological under this subsection that is furnished during the period beginning on October 1, 2018, and ending on March 31, 2019, shall be the greater of—

(i) the payment amount that would otherwise apply under subparagraph (D)(i) for such drug or biological during such period; or

(ii) the payment amount that applied under such subparagraph (D)(i) for such drug or biological on December 31, 2017.

(I) Special payment adjustment rules for last quarter of 2018

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment amount for a covered OPD service (or group of services) beginning January 1, 2018, the following rules shall apply with respect to payment amounts under this subsection for covered a OPD[14] service (or group of services) furnished during the period beginning on October 1, 2018, and ending on December 31, 2018:

(i) The Secretary shall remove the packaged costs of such drug or biological (as determined by the Secretary) from the payment amount under this subsection for the covered OPD service (or group of services) with which it is packaged.

(ii) The Secretary shall not make any adjustments to payment amounts under this subsection for a covered OPD service (or group of services) for which no costs were removed under clause (i).

(J) Additional pass-through extension and special payment adjustment rule for certain diagnostic radiopharmaceuticals

In the case of a drug or biological furnished in the context of a clinical study on diagnostic imaging tests approved under a coverage with evidence development determination whose period of pass-through status under this paragraph concluded on December 31, 2018, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2019, the Secretary shall—

(i) extend such pass-through status for such drug or biological for the 9-month period beginning on January 1, 2020;

(ii) remove, during such period, the packaged costs of such drug or biological (as determined by the Secretary) from the payment amount under this subsection for the covered OPD service (or group of services) with which it is packaged; and

(iii) not make any adjustments to payment amounts under this subsection for a covered OPD service (or group of services) for which no costs were removed under clause (ii).

(7) Transitional adjustment to limit decline in payment

(A) Before 2002

Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA

[14] So in original. Probably should be ''a covered OPD''.

amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002

Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003

Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) Hold harmless provisions

(i) Temporary treatment for certain rural hospitals

(I) In the case of a hospital located in a rural area and that has not more than 100 beds or a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) located in a rural area, for covered OPD services furnished before January 1, 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, 2010, 2011, or 2012.

(III) In the case of a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before March 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.

(ii) Permanent treatment for cancer hospitals and children's hospitals

In the case of a hospital described in clause (iii) or (v) of section 1395ww(d)(1)(B) of this title, for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(E) PPS amount defined

In this paragraph, the term ''PPS amount'' means, with respect to covered OPD services, the amount payable under this subchapter for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1395cc(a)(2)(A)(ii) of this title, and the deductible under subsection (b).

(F) Pre-BBA amount defined

(i) In general

In this paragraph, the ''pre-BBA amount'' means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

(ii) Base payment-to-cost ratio defined

For purposes of this subparagraph, the ''base payment-to-cost ratio'' for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report), including any re-

imbursement for such services through cost-sharing described in subparagraph (E), to

(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) Interim payments

The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) No effect on copayments

Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) Application without regard to budget neutrality

The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) Copayment amount

(A) In general

Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) Election to offer reduced copayment amount

The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) Limitation on copayment amount

(i) To inpatient hospital deductible amount

In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1395e(b) of this title for that year.

(ii) To specified percentage

The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) No impact on deductibles

Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under subsection (b).

(E) Computation ignoring outlier and pass-through adjustments

The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(9) Periodic review and adjustments components of prospective payment system

(A) Periodic review

The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) Budget neutrality adjustment

If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).

(C) Update factor

If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts estab-

lished through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) Special rule for ambulance services

The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1395x(v)(1)(U) of this title, or, if applicable, the fee schedule established under section 1395m(*l*) of this title.

(11) Special rules for certain hospitals

In the case of hospitals described in clause (iii) or (v) of section 1395ww(d)(1)(B) of this title—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) Limitation on review

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

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) Authorization of adjustment for rural hospitals

(A) Study

The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) Authorization of adjustment

Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14) Drug APC payment rates

(A) In general

The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1395u(*o*) of this title, section 1395w–3a of this title, or section 1395w–3b of this title, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) Specified covered outpatient drug defined

(i) In general

In this paragraph, the term ''specified covered outpatient drug'' means, subject to clause (ii), a covered outpatient drug (as defined in section 1396r–8(k)(2) of this title) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (re-

lating to pass-through payments) on or before December 31, 2002.

(ii) Exception

Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) Payment for designated orphan drugs during 2004 and 2005

The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) Acquisition cost survey for hospital outpatient drugs

(i) Annual GAO surveys in 2004 and 2005

(I) In general

The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) Recommendations

Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) Subsequent secretarial surveys

The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) Survey requirements

The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) Differentiation in cost

In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) Comment on proposed rates

Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

(E) Adjustment in payment rates for overhead costs

(i) MedPAC report on drug APC design

The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) Adjustment authorized

The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) Classes of drugs

For purposes of this paragraph:

(i) Sole source drugs

The term ''sole source drug'' means—

(I) a biological product (as defined under section 1395x(t)(1) of this title); or

(II) a single source drug (as defined in section 1396r–8(k)(7)(A)(iv) of this title).

(ii) Innovator multiple source drugs

The term ''innovator multiple source drug'' has the meaning given such term in section 1396r–8(k)(7)(A)(ii) of this title.

(iii) Noninnovator multiple source drugs

The term ''noninnovator multiple source drug'' has the meaning given such term in section 1396r–8(k)(7)(A)(iii) of this title.

(G) Reference average wholesale price

The term ''reference average wholesale price'' means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1395u(*o*) of this title as of May 1, 2003.

(H) Inapplicability of expenditures in determining conversion, weighting, and other adjustment factors

Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15) Payment for new drugs and biologicals until HCPCS code assigned

With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.

(16) Miscellaneous provisions

(A) Application of reclassification of certain hospitals

If a hospital is being treated as being located in a rural area under section 1395ww(d)(8)(E) of this title, that hospital shall be treated under this subsection as being located in that rural area.

(B) Threshold for establishment of separate APCS for drugs

The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) Payment for devices of brachytherapy and therapeutic radiopharmaceuticals at charges adjusted to cost

Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2010, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be included in determining any outlier payment under this subsection.

(D) Special payment rule

(i) In general

In the case of covered OPD services furnished on or after April 1, 2013, in a hospital described in clause (ii), if—

(I) the payment rate that would otherwise apply under this subsection for stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session that is multisource Cobalt 60 based (identified as of January 1, 2013, by HCPCS code 77371 (and any succeeding code) and reimbursed as of such date under APC 0127 (and any succeeding classification group)); exceeds

(II) the payment rate that would otherwise apply under this subsection for linear accelerator based stereotactic radiosurgery, complete course of therapy in one session (identified as of January 1, 2013, by HCPCS code G0173 (and any succeeding code) and reimbursed as of such date under APC 0067 (and any succeeding classification group)),

the payment rate for the service described in subclause (I) shall be reduced to an amount equal to the payment rate for the service described in subclause (II).

(ii) Hospital described

A hospital described in this clause is a hospital that is not—

(I) located in a rural area (as defined in section 1395ww(d)(2)(D) of this title);

(II) classified as a rural referral center under section 1395ww(d)(5)(C) of this title; or

(III) a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title).

(iii) Not budget neutral

In making any budget neutrality adjustments under this subsection for 2013 (with respect to covered OPD services furnished on or after April 1, 2013, and before January 1, 2014) or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(E) Application of appropriate use criteria for certain imaging services

For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1395m(q) of this title.

(F) Payment incentive for the transition from traditional X-ray imaging to digital radiography

Notwithstanding the previous provisions of this subsection:

(i) Limitation on payment for film X-ray imaging services

In the case of an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 20 percent.

(ii) Phased-in limitation on payment for computed radiography imaging services

In the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1395w–4(b)(9)(C) of this title)—

(I) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 7 percent; and

(II) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 10 percent.

(iii) Application without regard to budget neutrality

The reductions made under this subparagraph—

(I) shall not be considered an adjustment under paragraph (2)(E); and

(II) shall not be implemented in a budget neutral manner.

(iv) Implementation

In order to implement this subparagraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(17) Quality reporting

(A) Reduction in update for failure to report

(i) In general

For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) Non-cumulative application

A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) Form and manner of submission

Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

(C) Development of outpatient measures

(i) In general

The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) Construction

Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1395ww(b)(3)(B)(viii) of this title.

(D) Replacement of measures

For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(E) Availability of data

The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(18) Authorization of adjustment for cancer hospitals

(A) Study

The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) Authorization of adjustment

Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall, subject to subparagraph (C), provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(C) Target PCR adjustment

In applying section 419.43(i) of title 42 of the Code of Federal Regulations to imple-

ment the appropriate adjustment under this paragraph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1395ww(d)(1)(B)(v) of this title. In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(19) Floor on area wage adjustment factor for hospital outpatient department services in frontier States

(A) In general

Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1395ww(d)(3)(E)(iii)(II) of this title) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) Limitation

This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1395ww(d)(5)(H) of this title.

(20) Not budget neutral application of reduced expenditures resulting from quality incentives for computed tomography

The Secretary shall not take into account the reduced expenditures that result from the application of section 1395m(p) of this title in making any budget neutrality adjustments this[15] subsection.

(21) Services furnished by an off-campus outpatient department of a provider

(A) Applicable items and services

For purposes of paragraph (1)(B)(v) and this paragraph, the term ''applicable items and services'' means items and services other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).

(B) Off-campus outpatient department of a provider

(i) In general

For purposes of paragraph (1)(B)(v) and this paragraph, subject to the subsequent provisions of this subparagraph, the term ''off-campus outpatient department of a provider'' means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of November 2, 2015) that is not located—

(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or

(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2)).

(ii) Exception

For purposes of paragraph (1)(B)(v) and this paragraph, the term ''off-campus outpatient department of a provider'' shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015.

(iii) Deemed treatment for 2017

For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

(iv) Alternative exception beginning with 2018

For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term ''off-campus outpatient department of a provider'' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after December 13, 2016), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1395cc(j) of this title; and

(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after December 13, 2016, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

(v) Mid-build requirement described

The mid-build requirement of this clause is, with respect to a department of a pro-

[15] So in original. Probably should be preceded by ''under''.

vider, that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department.

(vi) Exclusion for certain cancer hospitals

For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term ''off-campus outpatient department of a provider'' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1395ww(d)(1)(B)(v) of this title and—

(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before December 13, 2016, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date; or

(II) in the case of a department that meets such requirements after such date, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.

(vii) Audit

Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term ''off-campus outpatient department of a provider'' under such clause.

(viii) Implementation

For purposes of implementing clauses (iii) through (vii):

(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

(II) Subchapter I of chapter 35 of title 44 shall not apply.

(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until December 31, 2018. For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until expended.

(C) Availability of payment under other payment systems

Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) shall be made under the applicable payment system under this part (other than under this subsection) if the requirements for such payment are otherwise met.

(D) Information needed for implementation

Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph and paragraph (1)(B)(v) (which may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form described in section 1395cc(j) of this title).

(E) Limitations

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(i) The determination of the applicable items and services under subparagraph (A) and applicable payment systems under subparagraph (C).

(ii) The determination of whether a department of a provider meets the term described in subparagraph (B).

(iii) Any information that hospitals are required to report pursuant to subparagraph (D).

(iv) The determination of an audit under subparagraph (B)(vii).

(22) Review and revisions of payments for non-opioid alternative treatments

(A) In general

With respect to payments made under this subsection for covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification, the Secretary—

(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;

(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and

(iii) shall consider the extent to which revisions under this subsection to such

payments (such as the creation of additional groups of covered OPD services to classify separately those procedures that utilize opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

(B) Priority

In conducting the review under clause (i) of subparagraph (A) and considering revisions under clause (iii) of such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification, ambulatory payment classifications that primarily include surgical services, and other services determined by the Secretary which generally involve treatment for pain management.

(C) Revisions

If the Secretary identifies revisions to payments pursuant to subparagraph (A)(iii), the Secretary shall, as determined appropriate, begin making such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (9)(B).

(D) Rules of construction

Nothing in this paragraph shall be construed to preclude the Secretary—

(i) from conducting a demonstration before making the revisions described in subparagraph (C); or

(ii) prior to implementation of this paragraph, from changing payments under this subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.

(u) Incentive payments for physician scarcity areas

(1) In general

In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) Determination of ratios of physicians to medicare beneficiaries in area

Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) Number of physicians practicing in the area

The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) Number of medicare beneficiaries residing in the area

The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as ''individuals'').

(C) Determination of ratios

(i) Primary care ratio

The ratio (in this paragraph referred to as the ''primary care ratio'') of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) Specialist care ratio

The ratio (in this paragraph referred to as the ''specialist care ratio'') of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) Ranking of counties

The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) Identification of counties

(A) In general

The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as ''primary care scarcity counties'') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

(ii) those counties and areas (in this subsection referred to as ''specialist care scarcity counties'') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) Periodic revisions

The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) Identification of counties where service is furnished

For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) Special rule

With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.

(E) Judicial review

There shall be no administrative or judicial review under section 1395ff, 1395*oo* of this title, or otherwise, respecting—

(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) Rural census tracts

To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) Physician defined

For purposes of this paragraph, the term ''physician'' means a physician described in section 1395x(r)(1) of this title and the term ''primary care physician'' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) Publication of list of counties; posting on website

With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1395w–4 of this title for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(v) Increase of FQHC payment limits

In the case of services furnished by Federally qualified health centers (as defined in section 1395x(aa)(4) of this title), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year.

(w) Methods of payment

The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.

(x) Incentive payments for primary care services

(1) In general

In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) Definitions

In this subsection:

(A) Primary care practitioner

The term ''primary care practitioner'' means an individual—

(i) who—

(I) is a physician (as described in section 1395x(r)(1) of this title) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1395x(aa)(5) of this title); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) Primary care services

The term ''primary care services'' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99304 through 99340.

(iii) 99341 through 99350.

(3) Coordination with other payments

The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) Incentive payments for major surgical procedures furnished in health professional shortage areas

(1) In general

In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 254e(a)(1)(A) of this title) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) Definitions

In this subsection:

(A) General surgeon

In this subsection, the term ''general surgeon'' means a physician (as described in section 1395x(r)(1) of this title) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1395cc(j) of this title.

(B) Major surgical procedures

The term ''major surgical procedures'' means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1395w–4(b) of this title.

(3) Coordination with other payments

The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) Application

The provisions of paragraph[16] (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(z) Incentive payments for participation in eligible alternative payment models

(1) Payment incentive

(A) In general

In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

(B) Form of payment

Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) Treatment of payment incentive

Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) Coordination

The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

(2) Qualifying APM participant

For purposes of this subsection, the term ''qualifying APM participant'' means the following:

[16] So in original. Probably should be ''paragraphs''.

(A) 2019 and 2020

With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(B) 2021 through 2024

With respect to each of 2021 through 2024, an eligible professional described in either of the following clauses:

(i) Medicare payment threshold option

An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) Combination all-payer and medicare payment threshold option

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under subchapter XIX in a State in which no medical home or alternative payment model is available under the State program under that subchapter),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) Requirement

For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds[17] expected aggregate expenditures; or

(BB) with respect to beneficiaries under subchapter XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1315a(c) of this title.

(C) Beginning in 2025

With respect to 2025 and each subsequent year, an eligible professional described in either of the following clauses:

(i) Medicare payment threshold option

An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) Combination all-payer and medicare payment threshold option

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under subchapter XIX in a State in which no medical home or alternative payment model is available under the State program under that subchapter),

meet the requirement described in clause (iii)(I) with respect to payments de-

[17] So in original. Probably should be ''exceed''.

scribed in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) Requirement

For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds[17] expected aggregate expenditures; or

(BB) with respect to beneficiaries under subchapter XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1315a(c) of this title.

(D) Use of patient approach

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1395w–4(q)(1)(C)(iii) of this title by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate. With respect to 2023 and 2024, the Secretary shall use the same percentage criteria for counts of patients that are used in 2022.

(3) Additional definitions

In this subsection:

(A) Covered professional services

The term ''covered professional services'' has the meaning given that term in section 1395w–4(k)(3)(A) of this title.

(B) Eligible professional

The term ''eligible professional'' has the meaning given that term in section 1395w–4(k)(3)(B) of this title and includes a group that includes such professionals.

(C) Alternative payment model (APM)

The term ''alternative payment model'' means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

(i) A model under section 1315a of this title (other than a health care innovation award).

(ii) The shared savings program under section 1395jjj of this title.

(iii) A demonstration under section 1395cc–3 of this title.

(iv) A demonstration required by Federal law.

(D) Eligible alternative payment entity

The term ''eligible alternative payment entity'' means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (*o*)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title; and

(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1315a(c) of this title.

(4) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo*[18] of this title, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

(aa) Medical review of spinal subluxation services

(1) In general

The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1395x(r)(5) of this title by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services fur-

[18] So in original. Probably should be preceded by ''section''.

nished on or after January 1, 2017, focusing on services such as—

(A) services furnished by a such a[1] chiropractor whose pattern of billing is aberrant compared to peers; and

(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

(2) Medical review

(A) Prior authorization medical review

(i) In general

Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1395x(r)(5) of this title that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

(ii) Ending application of prior authorization medical review

The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

(iii) Early request for prior authorization review permitted

Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

(B) Type of review

The Secretary may use pre-payment review or post-payment review of services described in section 1395x(r)(5) of this title that are not subject to prior authorization medical review under subparagraph (A).

(C) Relationship to law enforcement activities

The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

(3) No payment without prior authorization

With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

(A) Prior authorization determination

The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1395y(a)(1)(A) of this title.

(B) Denial of payment

Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1395y(a)(1)(A) of this title.

(4) Submission of information

A chiropractor described in section 1395x(r)(5) of this title may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

(5) Timeliness

If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

(6) Application of limitation on beneficiary liability

Where payment may not be made as a result of the application of paragraph (2)(B), section 1395pp of this title shall apply in the same manner as such section applies to a denial that is made by reason of section 1395y(a)(1) of this title.

(7) Review by contractors

The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1395kk–1(a)(4)(G) of this title or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

(8) Multiple services

The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) Construction

With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this chapter.

(10) Implementation

(A) Authority

The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) Administration

Chapter 35 of title 44 shall not apply to medical review under this subsection.

(bb) Additional payments for certain rural health clinics with physicians or practitioners receiving data 2000 waivers

(1) In general

In the case of a rural health clinic with respect to which, beginning on or after January 1, 2019, rural health clinic services (as defined in section 1395x(aa)(1) of this title) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in paragraph (3), the Secretary shall, subject to availability of funds under paragraph (4), make a payment (at such time and in such manner as specified by the Secretary) to such rural health clinic after receiving and approving an application described in paragraph (2). Such payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in paragraph (3)(B). Such payment may be made only one time with respect to each such physician or practitioner.

(2) Application

In order to receive a payment described in paragraph (1), a rural health clinic shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A rural health clinic may apply for such a payment for each physician or practitioner described in paragraph (1) furnishing services described in such paragraph at such clinic.

(3) Requirements

For purposes of paragraph (1), the requirements described in this paragraph, with respect to a physician or practitioner, are the following:

(A) The physician or practitioner is employed by or working under contract with a rural health clinic described in paragraph (1) that submits an application under paragraph (2).

(B) The physician or practitioner first receives a waiver under section 823(g) of title 21 on or after January 1, 2019.

(4) Funding

For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.

(cc) Specified COVID–19 testing-related services

For purposes of subsection (a)(1)(DD):

(1) Description

(A) In general

A specified COVID–19 testing-related service described in this paragraph is a medical visit that—

(i) is in any of the categories of HCPCS evaluation and management service codes described in subparagraph (B);

(ii) is furnished during any portion of the emergency period (as defined in section 1320b–5(g)(1)(B) of this title) (beginning on or after March 18, 2020);

(iii) results in an order for or administration of a clinical diagnostic laboratory test described in section 1395w–22(a)(1)(B)(iv)(IV) of this title; and

(iv) relates to the furnishing or administration of such test or to the evaluation of such individual for purposes of determining the need of such individual for such test.

(B) Categories of HCPCS codes

For purposes of subparagraph (A), the categories of HCPCS evaluation and management services codes are the following:

(i) Office and other outpatient services.

(ii) Hospital observation services.

(iii) Emergency department services.

(iv) Nursing facility services.

(v) Domiciliary, rest home, or custodial care services.

(vi) Home services.

(vii) Online digital evaluation and management services.

(2) Specified outpatient payment provision

A specified outpatient payment provision described in this paragraph is any of the following:

(A) The hospital outpatient prospective payment system under subsection (t).

(B) The physician fee schedule under section 1395w–4 of this title.

(C) The prospective payment system developed under section 1395m(*o*) of this title.

(D) Section 1395m(g) of this title, with respect to an outpatient critical access hospital service.

(E) The payment basis determined in regulations pursuant to subsection (a)(3) for rural health clinic services.

(dd) Special coinsurance rule for certain colorectal cancer screening tests

(1) In general

In the case of a colorectal cancer screening test to which paragraph (1)(Y) of subsection (a) would not apply but for the third sentence of such subsection that is furnished during a year beginning on or after January 1, 2022, and before January 1, 2030, the amount paid shall be equal to the specified percent (as defined in paragraph (2)) for such year of the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to such test under this part (or, in the case such test is a covered OPD service (as defined in subsection (t)(1)(B)), the amount determined under subsection (t)).

(2) Specified percent defined

For purposes of paragraph (1), the term ''specified percent'' means—

(A) for 2022, 80 percent;

(B) for 2023 through 2026, 85 percent; and

(C) for 2027 through 2029, 90 percent.

(Aug. 14, 1935, ch. 531, title XVIII, § 1833, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 302; amended Pub. L. 90–248, title I,

§§ 129(c)(7), (8), 131(a), (b), 132(b), 135(c), Jan. 2, 1968, 81 Stat. 848–850, 853; Pub. L. 92–603, title II, §§ 204(a), 211(c)(4), 226(c)(2), 233(b), 245(d), 251(a)(2), (3), 279, 299K(a), Oct. 30, 1972, 86 Stat. 1377, 1384, 1404, 1411, 1424, 1445, 1454, 1464; Pub. L. 95–142, § 16(a), Oct. 25, 1977, 91 Stat. 1200; Pub. L. 95–210, § 1(b), Dec. 13, 1977, 91 Stat. 1485; Pub. L. 95–292, § 4(b), (c), June 13, 1978, 92 Stat. 315; Pub. L. 96–473, § 6(j), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 96–499, title IX, §§ 918(a)(4), 930(h), 932(a)(1), 934(b), (d)(1), (3), 935(a), 942, 943(a), Dec. 5, 1980, 94 Stat. 2626, 2631, 2634, 2637, 2639, 2641; Pub. L. 96–611, § 1(b)(1), (2), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§ 2106(a), 2133(a), 2134(a), Aug. 13, 1981, 95 Stat. 792, 797; Pub. L. 97–248, title I, §§ 101(c)(2), 112(a), (b), 117(a)(2), 148(d), Sept. 3, 1982, 96 Stat. 336, 340, 355, 394; Pub. L. 98–369, div. B, title III, §§ 2303(a)–(d), 2305(a)–(d), 2308(b)(2)(B), 2321(b), (d)(4)(A), 2323(b)(1), (2), (4), 2354(b)(5), (7), July 18, 1984, 98 Stat. 1064, 1069, 1070, 1074, 1084–1086, 1100; Pub. L. 98–617, § 3(b)(2), (3), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§ 9303(a)(1), (b)(1)–(3), 9401(b)–(2)(E), Apr. 7, 1986, 100 Stat. 188, 189, 198, 199; Pub. L. 99–509, title IX, §§ 9320(e)(1), (2), 9337(b), 9339(a)(1), (b)(1), (2), (c)(1), 9343(a), (b), (e)(2), Oct. 21, 1986, 100 Stat. 2014, 2033, 2036, 2039–2041; Pub. L. 100–203, title IV, §§ 4042(b)(2)(B), 4043(a), 4045(c)(2)(A), 4049(a)(1), 4055(a), formerly 4054(a), 4062(d)(3), 4063(b), (e)(1), 4064(a), (b)(1), (2), (c)(1), formerly (c), 4066(a), (b), 4067(a), 4068(a), 4070(a), (b)(4), 4072(b), 4073(b), formerly (b)(2), (3), 4077(b)(2), (3), formerly (b)(3), (4), 4084(a), (c)(2), 4085(b)(1), (i)(1)–(3), (21)(D)(i), (22)(B), (23), Dec. 22, 1987, 101 Stat. 1330–85, 1330–88, 1330–90, 1330–108 to 1330–115, 1330–117, 1330–118, 1330–120, 1330–121, 1330–129 to 1330–133, as amended Pub. L. 100–360, title IV, § 411(f)(2)(D), (8)(B)(i), (12)(A), (14), (g)(2)(E), (3)(A)–(C), (E), (F), (h)(3)(B), (4)(B), (C), (7)(C), (D), (F), (i)(3), (4)(C)(i), (ii), (iv), (vi), July 1, 1988, 102 Stat. 777, 779, 781, 783, 784, 786–789; Pub. L. 100–360, title I, § 104(d)(7), title II, §§ 201(a), 202(b)(1)–(3), 203(c)(1)(A)–(E), 204(d)(1), 205(c), 212(c)(2), title IV, § 411(f)(8)(C), (g)(1)(E), (2)(D), (3)(D), (4)(C), (5), (h)(1)(A), (i)(4)(B), July 1, 1988, 102 Stat. 699, 704, 722, 729, 730, 741, 779, 782–785, 789, as amended Pub. L. 100–485, title VI, § 608(d)(3)(G), Oct. 13, 1988, 102 Stat. 2414; Pub. L. 100–485, title VI, § 608(d)(4), (22)(B), (D), (23)(A), Oct. 13, 1988, 102 Stat. 2414, 2420, 2421; Pub. L. 100–647, title VIII, §§ 8421(a), 8422(a), Nov. 10, 1988, 102 Stat. 3802; Pub. L. 101–234, title II, §§ 201(a), 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6003(e)(2)(A), (g)(3)(D)(vii), 6102(c)(1), (e)(1), (5), (6)(A), (7), (f)(2), 6111(a), (b)(1), 6113(b)(3), (d), 6116(b)(1), 6131(a)(1), (b), 6133(a), 6204(b), Dec. 19, 1989, 103 Stat. 2143, 2153, 2184, 2187–2189, 2213, 2214, 2217, 2219, 2221, 2222, 2241; Pub. L. 101–508, title IV, §§ 4008(m)(2)(C), 4104(b)(1), 4118(f)(2)(D), 4151(c)(1), (2), 4153(a)(2)(B), (C), 4154(a), (b)(1), (c)(1), (e)(1), 4155(b)(2), (3), 4160, 4161(a)(3)(B), 4163(d)(1), 4206(b)(2), 4302, Nov. 5, 1990, 104 Stat. 1388–53, 1388–59, 1388–70, 1388–73, 1388–83 to 1388–87, 1388–91, 1388–93, 1388–100, 1388–116, 1388–125; Pub. L. 101–597, title IV, § 401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–66, title XIII, §§ 13516(b), 13532(a), 13544(b)(2), 13551, 13555(a), Aug. 10, 1993, 107 Stat. 584, 586, 590, 592; Pub. L. 103–432, title I, §§ 123(b)(2)(A), (e), 141(a), (c)(1), 147(a), (d), (e)(2), (3), (f)(6)(C), (D), 156(a)(2)(B), 160(d)(1), Oct. 31, 1994, 108 Stat. 4411, 4412, 4424, 4425, 4429, 4430, 4432, 4440, 4443; Pub. L. 105–33, title IV, §§ 4002(j)(1)(A), 4101(b), 4102(b), 4103(b), 4104(c)(1), (2), 4201(c)(1), 4205(a)(1)(A), (2), 4315(b), 4432(b)(5)(C), 4511(b), 4512(b)(1), 4521(a), (b), 4523(a), (d)(1)(A)(i), (B)–(3), 4531(b)(1), 4541(a)(1), (c), (d)(1), 4553(a), (b), 4555, 4556(b), 4603(c)(2)(A), Aug. 5, 1997, 111 Stat. 330, 360–362, 365, 373, 376, 390, 421, 442–445, 449, 450, 454, 456, 460, 462, 463, 470; Pub. L. 106–113, div. B, § 1000(a)(6) [title II, §§ 201(a)–(e)(1), (f)–(h)(1), (i), (j), 202(a), 204(a),(b), 211(a)(3)(B), 221(a)(1), 224(a), title III, § 321(g)(2), (k)(2), title IV, §§ 401(b)(1), 403(e)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336 to 1501A–342, 1501A–345, 1501A–348, 1501A–351, 1501A–353, 1501A–366, 1501A–369, 1501A–371; Pub. L. 106–554, § 1(a)(6) [title I, §§ 105(c), 111(a)(1), title II, §§ 201(b)(1), 205(b), 223(c), 224(a), title IV, §§ 401(a), (b)(1), 402(a), (b), 403(a), 405(a), 406(a), 421(a), 430(a), title V, § 531(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, 2763A–481, 2763A–483, 2763A–489, 2763A–490, 2763A–502, 2763A–503, 2763A–505 to 2763A–508, 2763A–516, 2763A–524, 2763A–547; Pub. L. 108–173, title II, § 237(a), title III, §§ 302(b)(2), 303(i)(3)(A), title IV, §§ 411(a)(1), (b), 413(a), (b)(1), title VI, §§ 614(a), (b), 621(a)(1)–(5), (b)(1), (2), 622, 624(a)(1), 626(a)–(c), 627(a), 628, 629, 642(b), title VII, § 736(b)(1), (2), title IX, § 942(b), Dec. 8, 2003, 117 Stat. 2212, 2229, 2254, 2274, 2275, 2277, 2306–2311, 2317–2322, 2355, 2421; Pub. L. 109–171, title V, §§ 5103, 5105, 5107(a)(1), 5112(e), 5113(a), Feb. 8, 2006, 120 Stat. 40–42, 44; Pub. L. 109–432, div. B, title I, §§ 107(a), (b)(1), 109(a)(1), (b), title II, § 201, Dec. 20, 2006, 120 Stat. 2983–2986; Pub. L. 110–173, title I, §§ 102, 105, 106, 113, Dec. 29, 2007, 121 Stat. 2495, 2496, 2501; Pub. L. 110–275, title I, §§ 101(a)(2), (b)(2), 102, 141, 142, 143(b)(2), (3), 145(a)(2), (b), 147, 151(a), 184, July 15, 2008, 122 Stat. 2497, 2498, 2542, 2543, 2547, 2548, 2550, 2587; Pub. L. 111–144, § 6, Mar. 2, 2010, 124 Stat. 46; Pub. L. 111–148, title III, §§ 3103, 3114, 3121, 3138, 3401(i), (k), (*l*), title IV, §§ 4103(c)(1), (3), (4), 4104(b), (c), title V, § 5501(a)(1), (b)(1), title X, §§ 10221(a), (b)(4), 10319(g), 10324(b), 10406, 10501(i)(3)(B), (C), Mar. 23, 2010, 124 Stat. 417, 423, 439, 485–487, 555–558, 652, 653, 935, 936, 949, 960, 975, 998, 999; Pub. L. 111–152, title I, § 1105(e), Mar. 30, 2010, 124 Stat. 1049; Pub. L. 111–309, title I, §§ 104, 108, Dec. 15, 2010, 124 Stat. 3287, 3288; Pub. L. 112–78, title III, §§ 304, 308, Dec. 23, 2011, 125 Stat. 1284, 1285; Pub. L. 112–96, title III, §§ 3002(a), 3005(a), (b), 3202, Feb. 22, 2012, 126 Stat. 186–188, 193; Pub. L. 112–240, title VI, §§ 603(a)–(c), 634, Jan. 2, 2013, 126 Stat. 2347, 2355; Pub. L. 113–67, div. B, title I, § 1103, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, § 103, title II, §§ 216(b)(1), 218(a)(2)(A), (b)(2), Apr. 1, 2014, 128 Stat. 1041, 1059, 1064, 1069; Pub. L. 114–10, title I, § 101(e)(2), (3), title II, § 202(a), (b)(1), title V, § 514(a), Apr. 16, 2015, 129 Stat. 117, 122, 143, 171; Pub. L. 114–74, title VI, § 603, Nov. 2, 2015, 129 Stat. 597; Pub. L. 114–113, div. O, title V, §§ 502(b), 504(b)(1), Dec. 18, 2015, 129 Stat. 3019, 3021; Pub. L. 114–255, div. A, title V, § 5012(c)(1), div. C, title XVI, §§ 16001(a), 16002(a), (b), Dec. 13, 2016, 130 Stat. 1202, 1324–1326; Pub. L. 115–123, div. E, title II, § 50202, Feb. 9, 2018, 132 Stat. 176; Pub. L. 115–141, div. S, title XIII, § 1301(a)(1), (2), Mar. 23, 2018, 132 Stat. 1149, 1150; Pub. L. 115–271, title II, § 2005(c)(1), title VI, §§ 6082, 6083(b), Oct. 24, 2018, 132 Stat. 3929, 3992, 3994; Pub. L. 116–94, div. N, title I, § 107(a), Dec. 20, 2019, 133 Stat. 3102; Pub. L. 116–127, div. F, § 6002(a), Mar. 18, 2020, 134

Stat. 202; Pub. L. 116–136, div. A, title III, §3713(b), Mar. 27, 2020, 134 Stat. 423; Pub. L. 116–159, div. C, title V, §2501(b)(2), Oct. 1, 2020, 134 Stat. 736; Pub. L. 116–260, div. CC, title I, §§114(a), 122(a), (b), 125(a)(2)(A), 130, Dec. 27, 2020, 134 Stat. 2948, 2955, 2956, 2963, 2973; Pub. L. 117–7, §2(a)(1), Apr. 14, 2021, 135 Stat. 251.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(a)(2)(A) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment note below.

Editorial Notes

REFERENCES IN TEXT

Section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (i)(2)(D)(i), is section 626(d) of Pub. L. 108–173, which is set out as a note under this section.

Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (*l*)(1)(C), is section 9320(k) of Pub. L. 99–509, as amended, which is set out as a note under section 1395k of this title.

The amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (*l*)(3)(B), are amendments made by section 9320 of Pub. L. 99–509, which amended sections 1395k, 1395*l*, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title and provisions set out as a note under section 1395ww of this title.

Section 4521 of The Balanced Budget Act of 1997, referred to in subsec. (t)(7)(F), is section 4521 of Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 444, which amended this section and enacted provisions set out as a note under this section.

CODIFICATION

Pub. L. 111–148, §10221(a), enacted into law S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, ''[e]xcept as provided in'' section 10221(b) of Pub. L. 111–148. Section 201(b) of S. 1790 would have amended this section but was stricken out by section 10221(b)(4) of Pub. L. 111–148.

AMENDMENTS

2021—Subsec. (f)(3)(A)(i). Pub. L. 117–7, §2(a)(1)(A)(i), added subcls. (I) and (II) and struck out former subcls. (I) and (II) which read as follows:

''(I) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or

''(II) the limit described in paragraph (2)(A); and''.

Subsec. (f)(3)(A)(ii)(I). Pub. L. 117–7, §2(a)(1)(A)(ii), substituted ''under subclause (I) or (II) of clause (i), as applicable,'' for ''under clause (i)(I)''.

Subsec. (f)(3)(B). Pub. L. 117–7, §2(a)(1)(B), added subpar. (B) and struck out former subpar. (B) which read as follows:

''(B) A rural health clinic described in this subparagraph is a rural health clinic that, as of December 31, 2019, was—

''(i) in a hospital with less than 50 beds; and

''(ii) enrolled under section 1395cc(j) of this title.''

2020—Subsec. (a). Pub. L. 116–260, §122(a), in concluding provisions, substituted ''section 1395m(*o*) of this title'' for ''section 1395m(0) of this title'', realigned margins, and inserted at end ''For services furnished on or after January 1, 2022, paragraph (1)(Y) shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''

Subsec. (a)(1)(Y). Pub. L. 116–260, §122(b)(1), inserted ''subject to subsection (dd),'' before ''with respect to''.

Subsec. (a)(1)(DD). Pub. L. 116–127, §6002(a)(1), which directed adding subpar. (DD) before the period at the end of par. (1), was executed by adding it before the semicolon at the end, to reflect the probable intent of Congress.

Subsec. (a)(10). Pub. L. 116–260, §125(a)(2)(A), added par. (10).

Subsec. (b)(11). Pub. L. 116–127, §6002(a)(2), added par. (11).

Subsec. (b)(12). Pub. L. 116–136 added par. (12).

Subsec. (f). Pub. L. 116–260, §130(2), (3)(A), (4), designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), and added pars. (2) and (3).

Subsec. (f)(1). Pub. L. 116–260, §130(3)(B), which directed insertion of ''prior to April 1, 2021'' after ''services provided'', was executed by making the insertion after ''services provided'' the second place appearing, to reflect the probable intent of Congress.

Subsec. (f)(2). Pub. L. 116–260, §130(1), inserted ''(before April 1, 2021)'' after ''in a subsequent year'' and substituted ''this paragraph'' for ''this subsection''.

Subsec. (j). Pub. L. 116–159 inserted before period at end ''(or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation), at a rate of 4 percent)''.

Subsec. (z)(2)(B). Pub. L. 116–260, §114(a)(1), substituted ''through 2024'' for ''and 2022'' in heading and ''each of 2021 through 2024'' for ''2021 and 2022'' in introductory provisions.

Subsec. (z)(2)(C). Pub. L. 116–260, §114(a)(2), substituted ''2025'' for ''2023'' in heading and introductory provisions.

Subsec. (z)(2)(D). Pub. L. 116–260, §114(a)(3), inserted at end ''With respect to 2023 and 2024, the Secretary shall use the same percentage criteria for counts of patients that are used in 2022.''

Subsec. (cc). Pub. L. 116–127, §6002(a)(3), added subsec. (cc).

Subsec. (dd). Pub. L. 116–260, §122(b)(2), added subsec. (dd).

2019—Subsec. (t)(6)(E)(i). Pub. L. 116–94, §107(a)(1), substituted ''2018 or 2020'' for ''2018''.

Subsec. (t)(6)(J). Pub. L. 116–94, §107(a)(2), added subpar. (J).

2018—Subsec. (a)(1)(CC). Pub. L. 115–271, §2005(c)(1), added subpar. (CC).

Subsec. (g)(1). Pub. L. 115–123, §50202(1), designated existing provisions as subpar. (A), inserted ''The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.'' after ''for purposes of subsections (a) and (b).'', and added subpar. (B).

Subsec. (g)(3). Pub. L. 115–123, §50202(2), designated existing provisions as subpar. (A), inserted ''The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.'' after ''for purposes of subsections (a) and (b).'', and added subpar. (B).

Subsec. (g)(5)(D). Pub. L. 115–123, §50202(3)(A), redesignated subpar. (D) as par. (8) of subsec. (g).

Subsec. (g)(5)(E)(iv). Pub. L. 115–123, §50202(3)(B), inserted '', except as such process is applied under paragraph (7)(B)'' before period at end.

Subsec. (g)(7). Pub. L. 115–123, §50202(4), added par. (7).

Subsec. (g)(8). Pub. L. 115–123, §50202(3)(A), redesignated par. (5)(D) as par. (8).

Subsec. (i)(8). Pub. L. 115–271, §6082(b), added par. (8).

Subsec. (t)(6)(C)(i). Pub. L. 115–141, §1301(a)(1)(A), substituted ''Subject to subparagraph (G), the payment'' for ''The payment'' in introductory provisions.

Subsec. (t)(6)(D)(i). Pub. L. 115–141, §1301(a)(1)(B), inserted ''subject to subparagraph (H),'' before ''in the case''.

Subsec. (t)(6)(E)(i). Pub. L. 115–141, §1301(a)(2), inserted at end ''This clause shall not apply for 2018.''

Subsec. (t)(6)(G) to (I). Pub. L. 115–141, §1301(a)(1)(C), inserted subpars. (G) to (I).

Subsec. (t)(22). Pub. L. 115–271, §6082(a), added par. (22).

Subsecs. (z), (aa). Pub. L. 115–271, §6083(b)(1), redesignated subsec. (z), relating to medical review of spinal subluxation services, as (aa).

Subsec. (bb). Pub. L. 115–271, §6083(b)(2), added subsec. (bb).

2016—Subsec. (a)(1)(BB). Pub. L. 114–255, §5012(c)(1), added subpar. (BB).

Subsec. (t)(18)(B). Pub. L. 114–255, §16002(b)(1), inserted '', subject to subparagraph (C),'' after ''shall''.

Subsec. (t)(18)(C). Pub. L. 114–255, §16002(b)(2), added subpar. (C).

Subsec. (t)(21)(B)(i). Pub. L. 114–255, §16001(a)(1)(A), substituted ''the subsequent provisions of this subparagraph'' for ''clause (ii)''.

Subsec. (t)(21)(B)(iii) to (v). Pub. L. 114–255, §16001(a)(1)(B), added cls. (iii) to (v).

Subsec. (t)(21)(B)(vi). Pub. L. 114–255, §16002(a)(1), added cl. (vi).

Subsec. (t)(21)(B)(vii). Pub. L. 114–255, §16002(a)(2), inserted after first sentence ''Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department.''

Pub. L. 114–255, §16001(a)(1)(B), added cl. (vii).

Subsec. (t)(21)(B)(viii). Pub. L. 114–255, §16001(a)(1)(B), added cl. (viii).

Subsec. (t)(21)(B)(viii)(III). Pub. L. 114–255, §16002(a)(3), inserted at end ''For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until expended.''

Subsec. (t)(21)(E)(iv). Pub. L. 114–255, §16001(a)(2), added cl. (iv).

2015—Subsec. (a)(1)(AA). Pub. L. 114–113, §504(b)(1), added subpar. (AA).

Subsec. (g)(5)(A). Pub. L. 114–10, §202(a)(1), substituted ''December 31, 2017'' for ''March 31, 2015''.

Subsec. (g)(5)(C)(i). Pub. L. 114–10, §202(b)(1)(A), inserted '', subject to subparagraph (E),'' after ''manual medical review process that''.

Subsec. (g)(5)(E). Pub. L. 114–10, §202(b)(1)(B), added subpar. (E).

Subsec. (g)(6)(A). Pub. L. 114–10, §202(a)(2), substituted ''December 31, 2017'' for ''March 31, 2015'' and ''2012 through 2017'' for ''2012, 2013, 2014, or the first three months of 2015''.

Subsec. (t)(1)(B)(v). Pub. L. 114–74, §603(1), added cl. (v).

Subsec. (t)(16)(F). Pub. L. 114–113, §502(b), added subpar. (F).

Subsec. (t)(21). Pub. L. 114–74, §603(2), added par. (21).

Subsec. (x)(3). Pub. L. 114–10, §101(e)(3)(A), inserted at end ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''

Subsec. (y)(3). Pub. L. 114–10, §101(e)(3)(B), inserted at end ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''

Subsec. (z). Pub. L. 114–10, §514(a), added subsec. (z) relating to medical review of spinal subluxation services.

Pub. L. 114–10, §101(e)(2), added subsec. (z) relating to incentive payments for participation in eligible alternative payment models.

2014—Subsec. (a)(1)(D)(i). Pub. L. 113–93, §216(b)(1)(A)(i)–(iii), designated existing provisions as subcl. (I), substituted ''subsection (h)(1) (for tests furnished before January 1, 2017)'' for ''subsection (h)(1)'', and added subcl. (II).

Subsec. (a)(1)(D)(ii). Pub. L. 113–93, §216(b)(1)(A)(iv), substituted ''for tests furnished before January 1, 2017, on the basis'' for ''on the basis''.

Subsec. (a)(2)(D)(i). Pub. L. 113–93, §216(b)(1)(B)(i)–(iii), designated existing provisions as subcl. (I), substituted ''subsection (h)(1) (for tests furnished before January 1, 2017)'' for ''subsection (h)(1)'', and added subcl. (II).

Subsec. (a)(2)(D)(ii). Pub. L. 113–93, §216(b)(1)(B)(iv), substituted ''for tests furnished before January 1, 2017, on the basis'' for ''on the basis''.

Subsec. (b)(3)(B). Pub. L. 113–93, §216(b)(1)(C), substituted ''for tests furnished before January 1, 2017, on the basis'' for ''on the basis''.

Subsec. (g)(5)(A). Pub. L. 113–93, §103(1), substituted ''March 31, 2015'' for ''March 31, 2014''.

Subsec. (g)(6)(A). Pub. L. 113–93, §103(2), substituted ''March 31, 2015'' for ''March 31, 2014'' and ''2012, 2013, 2014, or the first three months of 2015'' for ''2012, 2013, or the first three months of 2014''.

Subsec. (h)(2)(A)(i). Pub. L. 113–93, §216(b)(1)(D), substituted ''and, for tests furnished before April 1, 2014, subject to'' for ''and subject to''.

Subsec. (h)(3). Pub. L. 113–93, §216(b)(1)(E), in introductory provisions, substituted ''fee schedules (for tests furnished before January 1, 2017) or under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section'' for ''fee schedules''.

Subsec. (h)(6). Pub. L. 113–93, §216(b)(1)(F), substituted ''For tests furnished before January 1, 2017, in the case'' for ''In the case''.

Subsec. (h)(7). Pub. L. 113–93, §216(b)(1)(G), substituted ''and (4) and section 1395m–1 of this title'' for ''and (4)'' and ''under this part'' for ''under this subsection''.

Subsec. (t)(16)(E). Pub. L. 113–93, §218(b)(2), added subpar. (E).

Subsec. (t)(20). Pub. L. 113–93, §218(a)(2)(A), added par. (20).

2013—Subsec. (g)(5)(A). Pub. L. 113–67, §1103(1), substituted ''March 31, 2014'' for ''December 31, 2013'' in first sentence.

Pub. L. 112–240, §603(a)(1), substituted ''December 31, 2013'' for ''December 31, 2012'' in first sentence.

Subsec. (g)(5)(D). Pub. L. 112–240, §603(c), added subpar. (D).

Subsec. (g)(6). Pub. L. 112–240, §603(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (g)(6)(A). Pub. L. 113–67, §1103(2), substituted ''March 31, 2014'' for ''December 31, 2013'' and '', 2013, or the first three months of 2014'' for ''or 2013''.

Pub. L. 112–240, §603(a)(2), substituted ''December 31, 2013'' for ''December 31, 2012'' and inserted ''or 2013'' after ''during 2012''.

Subsec. (t)(16)(D). Pub. L. 112–240, §634, added subpar. (D).

2012—Subsec. (g)(1), (3). Pub. L. 112–96, §3005(b)(1), substituted ''but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)'' for ''but not described in subsection (a)(8)(B) of this section''.

Subsec. (g)(5). Pub. L. 112–96, §3005(a), designated existing provisions as subpar. (A), substituted ''December 31, 2012'' for ''February 29, 2012'', inserted ''and if the requirement of subparagraph (B) is met'' after ''determined to be medically necessary'' and ''made in accordance with such requirement'' after ''receipt of the request'', and added subpars. (B) and (C).

Subsec. (g)(6). Pub. L. 112–96, §3005(b)(2), added par. (6).

Subsec. (h)(2)(A)(i). Pub. L. 112–96, §3202(1), substituted ''clause (v), subparagraph (B), and paragraph (4)'' for ''paragraph (4)''.

Subsec. (h)(2)(A)(iv). Pub. L. 112–96, §3202(2), realigned margins.

Subsec. (h)(2)(A)(v). Pub. L. 112–96, §3202(3), added cl. (v).

Subsec. (t)(7)(D)(i)(II). Pub. L. 112–96, §3002(a)(1), substituted ''January 1, 2013'' for ''March 1, 2012'' and ''or 2012'' for ''or the first two months of 2012''.

Subsec. (t)(7)(D)(i)(III). Pub. L. 112–96, §3002(a)(2), substituted ''January 1, 2013, for which'' for ''March 1, 2012, for which''.

2011—Subsec. (g)(5). Pub. L. 112–78, §304, substituted ''February 29, 2012'' for ''December 31, 2011''.

Subsec. (t)(7)(D)(i)(II). Pub. L. 112–78, §308(1), substituted ''March 1, 2012'' for ''January 1, 2012'' and ''2011, or the first two months of 2012'' for ''or 2011''.

Subsec. (t)(7)(D)(i)(III). Pub. L. 112–78, §308(2), substituted ''2009, and before March 1, 2012, for which'' for ''2009, and before January 1, 2012, for which'' and ''2010, and before March 1, 2012, the preceding'' for ''2010, and before January 1, 2012, the preceding''.

2010—Subsec. (a). Pub. L. 111–148, §10501(i)(3)(C)(ii), inserted concluding provisions.

Subsec. (a)(1)(K). Pub. L. 111–148, §3114, inserted ''(or 100 percent for services furnished on or after January 1, 2011)'' after ''1992, 65 percent''.

Subsec. (a)(1)(N). Pub. L. 111–148, §4103(c)(1)(A), inserted ''other than personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title)'' after ''(as defined in section 1395w–4(j)(3) of this title)''.

Subsec. (a)(1)(T). Pub. L. 111–148, §4104(b)(1), as amended by Pub. L. 111–148, §10406, inserted ''(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)'' after ''80 percent''.

Subsec. (a)(1)(W). Pub. L. 111–148, §4104(b)(2), as amended by Pub. L. 111–148, §10406, inserted ''(if such subparagraph were applied, by substituting '100 percent' for '80 percent')'' after ''subparagraph (D)'' in cl. (i) and substituted ''100 percent'' for ''80 percent'' in cl. (ii).

Subsec. (a)(1)(X). Pub. L. 111–148, §4103(c)(1)(B), (C), added subpar. (X).

Subsec. (a)(1)(Y). Pub. L. 111–148, §4104(b)(3), (4), as amended by Pub. L. 111–148, §10406, added subpar. (Y).

Subsec. (a)(1)(Z). Pub. L. 111–148, §10501(i)(3)(B), added subpar. (Z).

Subsec. (a)(2)(F) to (H). Pub. L. 111–148, §4103(c)(3)(B), which directed amendment of par. (2) by striking ''and'' at end of subpar. (F), substituting ''; and'' for comma at end of subpar. (G)(ii), and adding subpar. (H) after subpar. (G)(ii), was executed as directed despite the presence of concluding provisions following subpar. (G)(ii), which were added as part of subpar. (G) by Pub. L. 105–33, §4603(c)(2)(A)(iv).

Subsec. (a)(3)(B)(i). Pub. L. 111–148, §10501(i)(3)(C)(i)(I), inserted subcl. (I) designation after ''otherwise been provided'' and '', or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1395m(*o*) of this title, under such section (calculated as if '100 percent' were substituted for '80 percent' in such section) for such services if the individual had not been so enrolled'' after ''been so enrolled''.

Subsec. (b). Pub. L. 111–148, §4104(c)(2), inserted at end ''Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''

Subsec. (b)(1). Pub. L. 111–148, §4104(c)(1), substituted ''preventive services described in subparagraph (A) of section 1395x(ddd)(3) of this title that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.'' for ''items and services described in section 1395x(s)(10)(A) of this title''.

Subsec. (b)(10). Pub. L. 111–148, §4103(c)(4), added par. (10).

Subsec. (g)(5). Pub. L. 111–309, §104, substituted ''and ending on December 31, 2011'' for ''and ending on March 31, 2010''.

Pub. L. 111–148, §3103, which directed substitution of ''December 31, 2010'' for ''December 31, 2009'', could not be executed because ''December 31, 2009'' did not appear subsequent to amendment by Pub. L. 111–144. See note below.

Pub. L. 111–144 substituted ''March 31, 2010'' for ''December 31, 2009''.

Subsec. (h)(2)(A)(i). Pub. L. 111–148, §3401(*l*)(1), inserted '', subject to clause (iv),'' after ''year) by'' and substituted ''and 2010'' for ''through 2013''.

Subsec. (h)(2)(A)(iv). Pub. L. 111–148, §3401(*l*)(2), added cl. (iv).

Subsec. (i)(2)(D)(v), (vi). Pub. L. 111–148, §3401(k), added cl. (v) and redesignated former cl. (v) as (vi).

Subsec. (t)(1)(B)(iv). Pub. L. 111–148, §4103(c)(3)(A), substituted '', diagnostic mammography, or personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title)'' for ''and diagnostic mammography''.

Subsec. (t)(2)(D). Pub. L. 111–148, §10324(b)(1), substituted ''subject to paragraph (19), the Secretary'' for ''the Secretary''.

Subsec. (t)(3)(C)(iv). Pub. L. 111–148, §3401(i)(1), inserted ''and subparagraph (F) of this paragraph'' after ''(17)''.

Subsec. (t)(3)(F). Pub. L. 111–148, §3401(i)(2), added subpar. (F).

Subsec. (t)(3)(G). Pub. L. 111–152, §1105(e)(3), struck out cl. (i) designation and heading, redesignated subcls. (I) to (V) of former cl. (i) as cls. (i) to (v), respectively, and realigned margins.

Pub. L. 111–148, §3401(i)(2), added subpar. (G).

Subsec. (t)(3)(G)(i)(I). Pub. L. 111–148, §10319(g)(1), struck out ''and'' at end.

Subsec. (t)(3)(G)(i)(II). Pub. L. 111–152, §1105(e)(1)(A), placed subcl. (II), which was directed to be inserted after subcl. (II) by Pub. 111–148, §10319(g)(3), immediately after subcl. (I) and struck out ''and'' at end. See Amendment note below.

Pub. L. 111–148, §10319(g)(3), which directed addition of subcl. (II) ''after subclause (II)'', could not be executed. See Amendment note above.

Subsec. (t)(3)(G)(i)(III). Pub. L. 111–152, §1105(e)(1), added subcl. (III) and struck out former subcl. (III) which read as follows: ''subject to clause (ii), for each of 2014 through 2019, 0.2 percentage point.''

Pub. L. 111–148, §10319(g)(4), substituted ''2014'' for ''2012''.

Pub. L. 111–148, §10319(g)(2), redesignated subcl. (II) as (III).

Subsec. (t)(3)(G)(i)(IV), (V). Pub. L. 111–152, §1105(e)(1)(B), added subcls. (IV) and (V).

Subsec. (t)(3)(G)(ii). Pub. L. 111–152, §1105(e)(2), struck out cl. (ii). Prior to amendment, text read as follows: ''Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

''(I) the excess (if any) of—

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

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

''(II) 5 percentage points.''

Subsec. (t)(7)(D)(i)(II). Pub. L. 111–309, §108(1), substituted ''2012'' for ''2011'' in first sentence and ''2010, or 2011'' for ''or 2010'' in second sentence.

Pub. L. 111–148, §3121(a)(1)(B), substituted '', 2009, or 2010'' for ''or 2009''.

Pub. L. 111–148, §3121(a)(1)(A), substituted ''2011'' for ''2010''.

Subsec. (t)(7)(D)(i)(III). Pub. L. 111–309, §108(2), which directed substitution of ''January 1, 2012'' for ''January

1, 2011'', was executed by making the substitution in two places to reflect the probable intent of Congress.

Pub. L. 111–148, §3121(b), inserted at end ''In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.''

Pub. L. 111–148, §3121(a)(2), substituted ''2009, and before January 1, 2011'' for ''2009, and before January 1, 2010''.

Subsec. (t)(18), (19). Pub. L. 111–148, §§3138, 10324(b)(2), added pars. (18) and (19).

Subsecs. (x), (y). Pub. L. 111–148, §5501(a)(1), (b)(1), added subsecs. (x) and (y).

2008—Subsec. (a)(1)(D)(iii). Pub. L. 110–275, §145(a)(2), before comma at end of subpar. (D), struck out cl. (iii), which read ''on the basis of a rate established under a demonstration project under section 1395w–3(e) of this title, the amount paid shall be equal to 100 percent of such rate''.

Subsec. (a)(1)(W). Pub. L. 110–275, §101(a)(2), added subpar. (W).

Subsec. (a)(8)(A), (B). Pub. L. 110–275, §143(b)(2), substituted '', outpatient speech-language pathology services,'' for ''(which includes outpatient speech-language pathology services)'' in introductory provisions.

Subsec. (b)(9). Pub. L. 110–275, §101(b)(2), added par. (9) at end of first sentence.

Subsec. (c). Pub. L. 110–275, §102, amended subsec. (c) generally. Prior to amendment, text read as follows: ''Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) of this section only 62½ percent of such expenses. For purposes of this subsection, the term 'treatment' does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.''

Subsec. (g)(1). Pub. L. 110–275, §143(b)(3), inserted ''and speech-language pathology services of the type described in such section through the application of section 1395x(*ll*)(2) of this title'' after ''1395x(p) of this title'' and ''and speech-language pathology services'' after ''and physical therapy services''.

Subsec. (g)(5). Pub. L. 110–275, §141, substituted ''December 31, 2009'' for ''June 30, 2008''.

Subsec. (h)(2)(A)(i). Pub. L. 110–275, §145(b), inserted ''minus, for each of the years 2009 through 2013, 0.5 percentage points'' after ''city average)''.

Subsec. (t)(7)(D)(i)(II). Pub. L. 110–275, §147(1), substituted ''January 1, 2010'' for ''January 1, 2009'' and ''For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008 or 2009.'' for ''For purposes of the previous sentence, with respect to covered OPD services furnished during 2006, 2007, or 2008, the applicable percentage shall be 95 percent, 90 percent, and 85 percent, respectively.''

Subsec. (t)(7)(D)(i)(III). Pub. L. 110–275, §147(2), added subcl. (III).

Subsec. (t)(16)(C). Pub. L. 110–275, §142, substituted ''January 1, 2010'' for ''July 1, 2008'' in two places.

Subsec. (v). Pub. L. 110–275, §151(a), added subsec. (v).

Subsec. (w). Pub. L. 110–275, §184, added subsec. (w).

2007—Subsec. (g)(5). Pub. L. 110–173, §105, substituted ''June 30, 2008'' for ''December 31, 2007''.

Subsec. (h)(9). Pub. L. 110–173, §113, added par. (9).

Subsec. (t)(16)(C). Pub. L. 110–173, §106, in heading, inserted ''and therapeutic radiopharmaceuticals'' before ''at charges'', in first sentence, substituted ''July 1, 2008'' for ''January 1, 2008'' and inserted ''and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before July 1, 2008,'' after ''July 1, 2008,'' and ''or therapeutic radiopharmaceutical'' after ''the device'' and after ''each device'', and, in second sentence, inserted ''or therapeutic radiopharmaceuticals'' after ''such devices''.

Subsec. (u)(1). Pub. L. 110–173, §102(1), substituted ''before July 1, 2008'' for ''before January 1, 2008'' in introductory provisions.

Subsec. (u)(4)(D), (E). Pub. L. 110–173, §102(2), added subpar. (D) and redesignated former subpar. (D) as (E).

2006—Subsec. (b)(7). Pub. L. 109–171, §5112(e), added par. (7) at end of first sentence.

Subsec. (b)(8). Pub. L. 109–171, §5113(a), added par. (8) at end of first sentence.

Subsec. (g)(1), (3). Pub. L. 109–171, §5107(a)(1)(A), substituted ''paragraphs (4) and (5)'' for ''paragraph (4)''.

Subsec. (g)(5). Pub. L. 109–432, §201, substituted ''the period beginning on January 1, 2006, and ending on December 31, 2007,'' for ''2006''.

Pub. L. 109–171, §5107(a)(1)(B), added par. (5).

Subsec. (i)(2)(A). Pub. L. 109–171, §5103(1), inserted ''subject to subparagraph (E),'' after ''subparagraph (D),''.

Subsec. (i)(2)(D)(ii). Pub. L. 109–171, §5103(2), inserted ''and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary'' before period at end.

Subsec. (i)(2)(D)(iv), (v). Pub. L. 109–432, §109(b)(1), added cl. (iv) and redesignated former cl. (iv) as (v).

Subsec. (i)(2)(E). Pub. L. 109–171, §5103(3), added subpar. (E).

Subsec. (i)(7). Pub. L. 109–432, §109(b)(2), added par. (7).

Subsec. (t)(2)(H). Pub. L. 109–432, §107(b)(1), inserted ''and for stranded and non-stranded devices furnished on or after July 1, 2007'' before period at end.

Subsec. (t)(3)(C)(iv). Pub. L. 109–432, §109(a)(1)(A), inserted ''subject to paragraph (17),'' after ''this subparagraph,''.

Subsec. (t)(7)(D)(i). Pub. L. 109–171, §5105, designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (t)(16)(C). Pub. L. 109–432, §107(a), substituted ''2008'' for ''2007''.

Subsec. (t)(17). Pub. L. 109–432, §109(a)(1)(B), added par. (17).

2003—Subsec. (a)(1)(D)(iii). Pub. L. 108–173, §302(b)(2)(C), added cl. (iii).

Subsec. (a)(1)(G). Pub. L. 108–173, §626(c), added subpar. (G).

Subsec. (a)(1)(S). Pub. L. 108–173, §642(b), inserted ''(including intravenous immune globulin (as defined in section 1395x(zz) of this title))'' after ''with respect to drugs and biologicals''.

Pub. L. 108–173, §303(i)(3)(A), inserted ''(or, if applicable, under section 1395w–3, 1395w–3a, or 1395w–3b of this title)'' after ''1395u(*o*) of this title''.

Subsec. (a)(1)(V). Pub. L. 108–173, §302(b)(2)(A), (B), added subpar. (V).

Subsec. (a)(2)(E)(i). Pub. L. 108–173, §614(b), inserted ''and, for services furnished on or after January 1, 2005, diagnostic mammography'' after ''screening mammography''.

Subsec. (a)(3). Pub. L. 108–173, §237(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: ''in the case of services described in section 1395k(a)(2)(D) of this title, the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1395x(v)(1)(A) of this title, less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title, but in no case may the payment for such services (other than for items and services described in section 1395x(s)(10)(A) of this title) exceed 80 percent of such costs;''.

Subsec. (b). Pub. L. 108–173, §629, substituted '', $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous

year increased by the annual percentage increase in the monthly actuarial rate under section 1395r(a)(1) of this title ending with such subsequent year (rounded to the nearest $1)'' for ''and $100 for 1991 and subsequent years'' before semicolon in first sentence.

Subsec. (g)(4). Pub. L. 108–173, §624(a)(1), substituted ''2002, 2004, and 2005'' for ''and 2002''.

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 108–173, §628, substituted '', 1998 through 2002, and 2004 through 2008'' for ''and 1998 through 2002''.

Subsec. (h)(5)(D). Pub. L. 108–173, §736(b)(1), substituted ''clinic,'' for ''clinic,,''.

Subsec. (h)(8). Pub. L. 108–173, §942(b), added par. (8).

Subsec. (i)(2)(A). Pub. L. 108–173, §626(b)(1)(A), substituted ''For services furnished prior to the implementation of the system described in subparagraph (D), the'' for ''The'' in introductory provisions.

Subsec. (i)(2)(A)(i). Pub. L. 108–173, §626(b)(1)(B), struck out ''taken not later than January 1, 1995, and every 5 years thereafter,'' before ''of the actual audited costs''.

Subsec. (i)(2)(C). Pub. L. 108–173, §626(a), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''

Subsec. (i)(2)(D). Pub. L. 108–173, §626(b)(2), added subpar. (D).

Subsec. (m). Pub. L. 108–173, §413(b)(1), designated existing provisions as par. (1), inserted ''in a year'' after ''In the case of physicians' services furnished'' and ''as identified by the Secretary prior to the beginning of such year'' after ''as a health professional shortage area'', and added pars. (2) to (4).

Subsec. (*o*)(1)(B). Pub. L. 108–173, §627(a)(1), substituted ''no more than the amount of payment applicable under paragraph (2)'' for ''no more than the limits established under paragraph (2)''.

Subsec. (*o*)(2). Pub. L. 108–173, §627(a)(2), amended par. (2) generally, substituting provisions relating to determination of amount of payments pursuant to section 1395m of this title for provisions specifying dollar amounts of payments.

Subsec. (t)(1)(B)(iv). Pub. L. 108–173, §614(a), inserted before period at end ''and does not include screening mammography (as defined in section 1395x(jj) of this title) and diagnostic mammography''.

Subsec. (t)(2)(H). Pub. L. 108–173, §621(b)(2), which directed the amendment of par. (2) by adding a new subpar. (H) at the end, was executed by adding subpar. (H) after subpar. (G), to reflect the probable intent of Congress.

Subsec. (t)(3)(C)(ii). Pub. L. 108–173, §736(b)(2), substituted ''clause (iv)'' for ''clause (iii)''.

Subsec. (t)(5)(E). Pub. L. 108–173, §621(a)(3), added subpar. (E).

Subsec. (t)(6)(D)(i). Pub. L. 108–173, §621(a)(4), inserted ''(or if the drug or biological is covered under a competitive acquisition contract under section 1395w–3b of this title, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)'' after ''under section 1395u(*o*) of this title''.

Subsec. (t)(6)(F). Pub. L. 108–173, §622, added subpar. (F).

Subsec. (t)(7)(D)(i). Pub. L. 108–173, §411(a)(1)(A), (C), substituted ''certain'' for ''small'' in heading and ''2006'' for ''2004'' in text.

Pub. L. 108–173, §411(a)(1)(B), inserted ''or a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) located in a rural area'' after ''100 beds''.

Subsec. (t)(9)(B). Pub. L. 108–173, §621(a)(5), inserted at end ''In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).''

Subsec. (t)(13). Pub. L. 108–173, §411(b)(2), added par. (13). Former par. (13) redesignated (16).

Subsec. (t)(14), (15). Pub. L. 108–173, §621(a)(1), added pars. (14) and (15).

Subsec. (t)(16). Pub. L. 108–173, §411(b)(1), redesignated par. (13) as (16).

Subsec. (t)(16)(B). Pub. L. 108–173, §621(a)(2), added subpar. (B).

Subsec. (t)(16)(C). Pub. L. 108–173, §621(b)(1), added subpar. (C).

Subsec. (u). Pub. L. 108–173, §413(a), added subsec. (u).

2000—Subsec. (a)(1)(D)(i). Pub. L. 106–554, §1(a)(6) [title II, §201(b)(1)], struck out ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

Subsec. (a)(1)(R). Pub. L. 106–554, §1(a)(6) [title II, §205(b)], substituted ''ambulance services, (i)'' for ''ambulance service,'' and inserted before comma at end ''and (ii) with respect to ambulance services described in section 1395m(*l*)(8) of this title, the amounts paid shall be the amounts determined under section 1395m(g) of this title for outpatient critical access hospital services''.

Subsec. (a)(1)(T). Pub. L. 106–554, §1(a)(6) [title I, §105(c)], added subpar. (T).

Subsec. (a)(1)(U). Pub. L. 106–554, §1(a)(6) [title II, §223(c)], added subpar. (U).

Subsec. (a)(2)(D)(i). Pub. L. 106–554, §1(a)(6) [title II, §201(b)(1)], struck out ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

Subsec. (f). Pub. L. 106–554, §1(a)(6) [title II, §224(a)], substituted ''hospitals'' for ''rural hospitals'' in introductory provisions.

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title IV, §421(a)], substituted ''2000, 2001, and 2002.'' for ''2000 and 2001.''

Subsec. (h)(4)(B)(viii). Pub. L. 106–554, §1(a)(6) [title V, §531(a)], inserted before period at end ''(or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph)''.

Subsec. (t)(2)(G). Pub. L. 106–554, §1(a)(6) [title IV, §430(a)], added subpar. (G).

Subsec. (t)(3)(C)(iii). Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(1)(B)], added cl. (iii). Former cl. (iii) redesignated (iv).

Pub. L. 106–554, §1(a)(6) [title IV, §401(a)], substituted ''in each of 2000 and 2002'' for ''in each of 2000, 2001, and 2002''.

Subsec. (t)(3)(C)(iv). Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(1)(A)], redesignated cl. (iii) as (iv).

Subsec. (t)(6)(A)(ii). Pub. L. 106–554, §1(a)(6) [title IV, §406(a)], inserted ''or temperature monitored cryoablation'' after ''device of brachytherapy''.

Subsec. (t)(6)(A)(iv)(II). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(1)], substituted ''the cost of the drug or biological or the average cost of the category of devices'' for ''the cost of the device, drug, or biological''.

Subsec. (t)(6)(B). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(2)], added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows: ''The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

''(i) on the first date this subsection is implemented in the case of a drug, biological, or device described

in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

''(ii) in the case of a device, drug, or biological described in subparagraph (A)(iv) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.''

Subsec. (t)(6)(C). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(2)], added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (t)(6)(D). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(2)], substituted ''subparagraph (E)(iii)'' for ''subparagraph (D)(iii)'' in introductory provisions.

Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(1)], redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (t)(6)(E). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(1)], redesignated subpar. (D) as (E).

Subsec. (t)(7)(D)(ii). Pub. L. 106–554, §1(a)(6) [title IV, §405(a)], in heading, inserted ''and children's hospitals'' after ''cancer hospitals'' and in text, substituted ''clause (iii) or (v) of section 1395ww(d)(1)(B) of this title'' for ''section 1395ww(d)(1)(B)(v) of this title''.

Subsec. (t)(7)(F)(ii)(I). Pub. L. 106–554, §1(a)(6) [title IV, §403(a)], inserted ''(or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report)'' after ''1996''.

Subsec. (t)(8)(C). Pub. L. 106–554, §1(a)(6) [title I, §111(a)(1)], amended heading and text of subpar. (C) generally. Prior to amendment, text read as follows: ''In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1395e(b) of this title for that year.''

Subsec. (t)(11). Pub. L. 106–554, §1(a)(6) [title IV, §405(a)(2)], substituted ''clause (iii) or (v) of section 1395ww(d)(1)(B) of this title'' for ''section 1395ww(d)(1)(B)(v) of this title'' in introductory provisions.

Subsec. (t)(12)(E). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(3)], substituted ''additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6))'' for ''additional payments (consistent with paragraph (6)(B))''.

1999—Subsec. (a)(1)(D)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)], inserted ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

Subsec. (a)(1)(O). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(2)], substituted a comma for the semicolon at end.

Subsec. (a)(2)(D)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)], inserted ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

Subsec. (g)(1), (3). Pub. L. 106–113, §1000(a)(6) [title II, §221(a)(1)(A)], substituted ''Subject to paragraph (4), in the case'' for ''In the case''.

Subsec. (g)(4). Pub. L. 106–113, §1000(a)(6) [title II, §221(a)(1)(B)], added par. (4).

Subsec. (h)(5)(A)(iii). Pub. L. 106–113, §1000(a)(6) [title III, §321(g)(2)], substituted '', critical access hospital, or skilled nursing facility,'' for ''or critical access hospital,'' and inserted ''or skilled nursing facility'' before period at end.

Subsec. (h)(7). Pub. L. 106–113, §1000(a)(6) [title II, §224(a)], added par. (7).

Subsec. (*l*)(4)(A)(i)(VII). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(B)], substituted ''1395w–4(d) of this title'' for ''1395w–4(d)(3) of this title''.

Subsec. (t)(1)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(A)], substituted ''clause (iv)'' for ''clause (iii)'' and directed the striking out of ''but'' which was executed by striking out ''but'' after semicolon at end to reflect the probable intent of Congress.

Subsec. (t)(1)(B)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(B)], added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (t)(2). Pub. L. 106–113, §1000(a)(6) [title II, §201(g)], inserted concluding provisions.

Subsec. (t)(2)(B). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(C)], inserted ''and so that an implantable item is classified to the group that includes the service to which the item relates'' before semicolon at end.

Subsec. (t)(2)(C). Pub. L. 106–113, §1000(a)(6) [title II, §201(f)], inserted ''(or, at the election of the Secretary, mean)'' after ''median''.

Subsec. (t)(2)(E). Pub. L. 106–113, §1000(a)(6) [title II, §201(c)], substituted '', in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as'' for ''other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or''.

Subsec. (t)(4). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(1)], inserted '', subject to paragraph (7),'' after ''is determined'' in introductory provisions.

Subsec. (t)(4)(C). Pub. L. 106–113, §1000(a)(6) [title II, §204(b)], inserted '', plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C)'' before period at end.

Subsec. (t)(5). Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(2)], added par. (5). Former par. (5) redesignated (7).

Subsec. (t)(6). Pub. L. 106–113, §1000(a)(6) [title II, §201(b)], added par. (6). Former par. (6) redesignated (8).

Subsec. (t)(7). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(3)], added par. (7). Former par. (7) redesignated (8).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (5) as (7). Former par. (7) redesignated (9).

Subsec. (t)(7)(D). Pub. L. 106–113, §1000(a)(6) [title II, §201(i)], added subpar. (D).

Subsec. (t)(8). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (7) as (8). Former par. (8) redesignated (9).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (6) as (8). Former par. (8) redesignated (10).

Subsec. (t)(8)(A). Pub. L. 106–113, §1000(a)(6) [title II, §204(a)(1)], substituted ''subparagraphs (B) and (C)'' for ''subparagraph (B)''.

Pub. L. 106–113, §1000(a)(6) [title II, §201(h)(1)(B)], inserted at end ''The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.''

Pub. L. 106–113, §1000(a)(6) [title II, §201(h)(1)(A)], substituted ''shall review not less often than annually'' for ''may periodically review''.

Subsec. (t)(8)(C) to (E). Pub. L. 106–113, §1000(a)(6) [title II, §204(a)(2), (3)], added subpar. (C) and redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsec. (t)(9). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (8) as (9). Former par. (9) redesignated (10).

Pub. L. 106–113, §1000(a)(6) [title II, §201(j)], substituted ''section 1395x(v)(1)(U) of this title'' for ''the matter in subsection (a)(1) of this section preceding subparagraph (A)''.

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (7) as (9). Former par. (9) redesignated (11).

Subsec. (t)(10). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (9) as (10). Former par. (10) redesignated (11).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (8) as (10).

Subsec. (t)(11). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (10) as (11). Former par. (11) redesignated (12).

Pub. L. 106–113, § 1000(a)(6) [title II, § 201(a)(1)], redesignated par. (9) as (11).

Subsec. (t)(11)(E). Pub. L. 106–113, § 1000(a)(6) [title II, § 201(d)], added subpar. (E).

Subsec. (t)(12). Pub. L. 106–113, § 1000(a)(6) [title II, § 202(a)(2)], redesignated par. (11) as (12).

Subsec. (t)(13). Pub. L. 106–113, § 1000(a)(6) [title IV, § 401(b)(1)], added par. (13).

1997—Subsec. (a)(1)(A). Pub. L. 105–33, § 4002(j)(1)(A), inserted ''(and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services)'' after ''prepayment basis''.

Subsec. (a)(1)(D). Pub. L. 105–33, § 4104(c), inserted ''or section 1395m(d)(1) of this title'' after ''subsection (h)(1)''.

Subsec. (a)(1)(O). Pub. L. 105–33, § 4512(b)(1), substituted ''section 1395x(s)(2)(K) of this title'' for ''section 1395x(s)(2)(K)(ii) of this title'' and ''services furnished by physician assistants, nurse practitioners, or clinic nurse specialists'' for ''nurse practitioner or clinical nurse specialist services''.

Pub. L. 105–33, § 4511(b)(1), amended subpar. (O) generally. Prior to amendment, subpar. (O) read as follows: ''with respect to services described in section 1395x(s)(2)(K)(iii) of this title (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2) of this section),''.

Subsec. (a)(1)(Q). Pub. L. 105–33, § 4315(b), added subpar. (Q).

Subsec. (a)(1)(R). Pub. L. 105–33, § 4531(b)(1), added subpar. (R).

Subsec. (a)(1)(S). Pub. L. 105–33, § 4556(b), added subpar. (S).

Subsec. (a)(2). Pub. L. 105–33, § 4541(a)(1)(A), inserted ''(C),'' before ''(D)'' in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 105–33, § 4603(c)(2)(A)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''with respect to home health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title)) and to items and services described in section 1395x(s)(10)(A) of this title, the lesser of—

''(i) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title;''.

Subsec. (a)(2)(B). Pub. L. 105–33, § 4432(b)(5)(C), inserted ''or section 1395yy(e)(9) of this title'' after ''1395ww of this title'' in introductory provisions.

Pub. L. 105–33, § 4523(d)(3), inserted ''furnished before January 1, 1999,'' after ''(i)'' in cl. (i), inserted ''before January 1, 1999,'' after ''furnished'' in cl. (ii), added cl. (iii), and redesignated former cl. (iii) as (iv).

Subsec. (a)(2)(D). Pub. L. 105–33, § 4104(c)(1), inserted ''or section 1395m(d)(1) of this title'' after ''subsection (h)(1)''.

Subsec. (a)(2)(E). Pub. L. 105–33, § 4523(d)(2)(B), inserted ''or, for services or procedures performed on or after January 1, 1999, subsection (t)'' before semicolon at end.

Subsec. (a)(2)(G). Pub. L. 105–33, § 4603(c)(2)(A)(ii)–(iv), added subpar. (G).

Subsec. (a)(3). Pub. L. 105–33, § 4541(a)(1)(B), substituted ''section 1395k(a)(2)(D) of this title'' for ''subparagraphs (D) and (E) of section 1395k(a)(2) of this title''.

Subsec. (a)(4). Pub. L. 105–33, § 4523(d)(1)(B), inserted ''or subsection (t)'' before semicolon at end.

Subsec. (a)(6). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (a)(8), (9). Pub. L. 105–33, § 4541(a)(1)(C)–(E), added pars. (8) and (9).

Subsec. (b)(5). Pub. L. 105–33, § 4101(b), added par. (5) at end of first sentence.

Subsec. (b)(6). Pub. L. 105–33, § 4102(b), added par. (6) at end of first sentence.

Subsec. (f). Pub. L. 105–33, § 4205(a)(1)(A), substituted ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)'' for ''independent rural health clinics'' in introductory provisions.

Subsec. (f)(1). Pub. L. 105–33, § 4205(a)(2), inserted ''per visit'' after ''$46''.

Subsec. (g). Pub. L. 105–33, § 4541(d)(1), substituted ''the amount specified in paragraph (2) for the year'' for ''$900'' in two places, redesignated first sentence as par. (1) and last sentence as par. (3), and added par. (2).

Pub. L. 105–33, § 4541(c), (d)(1)(A), substituted, in first sentence, ''physical therapy services of the type described in section 1395x(p) of this title, but not described in subsection (a)(8)(B) of this section, and physical therapy services of such type which are furnished by a physician or as incident to physicians' services'' for ''services described in the second sentence of section 1395x(p) of this title'', and substituted, in last sentence, ''occupational therapy services (of the type that are described in section 1395x(p) of this title (but not described in subsection (a)(8)(B) of this section) through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services)'' for ''outpatient occupational therapy services which are described in the second sentence of section 1395x(p) of this title through the operation of section 1395x(g) of this title''.

Subsec. (h)(1)(A). Pub. L. 105–33, § 4104(c)(2), substituted ''Subject to section 1395m(d)(1) of this title, the Secretary'' for ''The Secretary''.

Pub. L. 105–33, § 4103(b), inserted ''(including prostate cancer screening tests under section 1395x(*oo*) of this title consisting of prostate-specific antigen blood tests)'' after ''laboratory tests''.

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 105–33, § 4553(a), inserted ''and 1998 through 2002'' after ''1995''.

Subsec. (h)(4)(B)(vii). Pub. L. 105–33, § 4553(b)(2)(A), inserted ''and before January 1, 1998,'' after ''December 31, 1995,''.

Subsec. (h)(4)(B)(viii). Pub. L. 105–33, § 4553(b)(1), (2)(B), (3), added cl. (viii).

Subsec. (h)(5)(A)(iii). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (i)(1)(A). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (i)(2)(C). Pub. L. 105–33, § 4555, inserted at end ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''

Subsec. (i)(3)(A). Pub. L. 105–33, § 4523(d)(1)(A)(i), inserted ''before January 1, 1999,'' after ''furnished'' and struck out ''in a cost reporting period'' after ''paragraph (1)(A)''.

Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (i)(3)(B)(i)(II). Pub. L. 105–33, § 4521(a), struck out ''of 80 percent'' before ''of the standard overhead amount'' and inserted before period at end '', less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title''.

Subsec. (*l*)(5). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care'' wherever appearing.

Subsec. (n)(1)(A). Pub. L. 105–33, § 4523(d)(2)(A), inserted ''and before January 1, 1999,'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

Subsec. (n)(1)(B)(i)(II). Pub. L. 105–33, § 4521(b), struck out ''of 80 percent'' before ''of the prevailing charge'' and inserted before period at end '', less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title''.

Subsec. (r)(1). Pub. L. 105–33, §4511(b)(2)(A), substituted ''section 1395x(s)(2)(K)(ii) of this title (relating to nurse practitioner or clinical nurse specialist services)'' for ''section 1395x(s)(2)(K)(iii) of this title (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)''.

Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (r)(2). Pub. L. 105–33, §4511(b)(2)(B), (D), redesignated par. (3) as (2) and struck out former par. (2) which read as follows:

''(2)(A) For purposes of subsection (a)(1)(O) of this section, the prevailing charge for services described in section 1395x(s)(2)(K)(iii) of this title may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) determined for such services performed by physicians who are not specialists.

''(B) In subparagraph (A), the term 'applicable percentage' means—

''(i) 75 percent in the case of services performed in a hospital, and

''(ii) 85 percent in the case of other services.''

Subsec. (r)(3). Pub. L. 105–33, §4511(b)(2)(C), (D), redesignated par. (3) as (2) and substituted ''section 1395x(s)(2)(K)(ii) of this title'' for ''section 1395x(s)(2)(K)(iii) of this title''.

Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (t). Pub. L. 105–33, §4523(a), added subsec. (t).

1994—Subsec. (a)(1)(D)(i). Pub. L. 103–432, §156(a)(2)(B)(i), struck out '', or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)'' after ''assignment-related basis''.

Subsec. (a)(1)(G). Pub. L. 103–432, §156(a)(2)(B)(ii), struck out subpar. (G) which read as follows: ''with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services,''.

Subsec. (a)(2)(A). Pub. L. 103–432, §156(a)(2)(B)(iii), struck out '', to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),'' before ''and to items and services'' in introductory provisions.

Pub. L. 103–432, §147(f)(6)(C)(i), substituted ''health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title))'' for ''health services'' in introductory provisions.

Subsec. (a)(2)(D)(i). Pub. L. 103–432, §156(a)(2)(B)(iv), substituted ''assignment-related basis or'' for ''assignment-related basis,'' and struck out '', or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)'' after ''section 1395cc of this title''.

Subsec. (a)(2)(F). Pub. L. 103–432, §147(f)(6)(C)(ii)–(iv), added subpar. (F).

Subsec. (a)(3). Pub. L. 103–432, §156(a)(2)(B)(v), struck out ''and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion)'' after ''section 1395x(s)(10)(A) of this title''.

Subsec. (b)(2). Pub. L. 103–432, §147(f)(6)(D), inserted ''(other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title))'' after ''services''.

Subsec. (b)(4), (5). Pub. L. 103–432, §156(a)(2)(B)(vi), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: ''such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),''.

Subsec. (h)(5)(D). Pub. L. 103–432, §123(e), substituted ''paragraph (2) of section 1395u(j)'' for ''paragraphs (2) and (3) of section 1395u(j)'' and inserted at end ''Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.''

Subsec. (i)(1). Pub. L. 103–432, §141(a)(3), inserted before period at end of last sentence '', in consultation with appropriate trade and professional organizations''.

Subsec. (i)(2)(A). Pub. L. 103–432, §141(a)(2)(A), struck out ''and may be adjusted by the Secretary, when appropriate,'' after ''annually thereafter'' in last sentence.

Subsec. (i)(2)(A)(i). Pub. L. 103–432, §141(a)(1), inserted before comma at end '', as determined in accordance with a survey (based upon a representative sample of procedures and facilities) taken not later than January 1, 1995, and every 5 years thereafter, of the actual audited costs incurred by such centers in providing such services''.

Subsec. (i)(2)(B). Pub. L. 103–432, §141(a)(2)(A), struck out ''and may be adjusted by the Secretary, when appropriate,'' after ''annually thereafter'' in last sentence.

Subsec. (i)(2)(C). Pub. L. 103–432, §141(a)(2)(B), added subpar. (C).

Subsec. (i)(3)(B)(ii). Pub. L. 103–432, §141(c)(1), in subcls. (I) and (II) substituted ''for portions of cost reporting periods'' for ''for reporting periods'' and ''and ending on or before December 31, 1990'' for ''and on or before December 31, 1990''.

Subsec. (*l*)(5)(B), (C). Pub. L. 103–432, §123(b)(2)(A)(i), redesignated subpar. (C) as (B) and struck out former subpar. (B) which read as follows:

''(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

''(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (n)(1)(B)(i)(II). Pub. L. 103–432, §147(d)(2), substituted ''April 1, 1989'' for ''January 1, 1989''.

Pub. L. 103–432, §147(d)(1), inserted ''and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992'' after ''January 1, 1989'' and ''(or, in the case of services furnished on or after January 1, 1992, under section 1395w–4 of this title)'' before period at end.

Subsec. (p). Pub. L. 103–432, §123(b)(2)(A)(ii), struck out subsec. (p) which read as follows: ''In the case of certified nurse-midwife services for which payment may be made under this part only pursuant to section 1395x(s)(2)(L) of this title, in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1395x(s)(2)(M) of this title, and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1395x(s)(2)(N) of this title, payment may only be made under this part for such

services on an assignment-related basis. Except for deductible and coinsurance amounts applicable under this section, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (q)(1). Pub. L. 103–432, §147(a), substituted ''unique physician identification number'' for ''provider number'' and struck out ''and indicate whether or not the referring physician is an interested investor (within the meaning of section 1395nn(h)(5) of this title)'' after ''for the referring physician''.

Subsec. (r). Pub. L. 103–432, §160(d)(1), redesignated subsec. (r), relating to other prepaid organizations, as (s).

Subsec. (r)(1). Pub. L. 103–432, §147(e)(2), substituted ''or ambulatory'' for ''ambulatory'' in two places and ''center'' for ''center,'' before ''with which the nurse''.

Subsec. (r)(2)(A). Pub. L. 103–432, §147(e)(3), substituted ''subsection (a)(1)(O) of this section'' for ''subsection (a)(1)(M) of this section''.

Subsec. (r)(3), (4). Pub. L. 103–432, §123(b)(2)(A)(iii), redesignated par. (4) as (3) and struck out former par. (3) which read as follows:

''(3)(A) Payment under this part for services described in section 1395x(s)(2)(K)(iii) of this title may be made only on an assignment-related basis, and any such assignment agreed to by a nurse practitioner or clinical nurse specialist shall be binding upon any other person presenting a claim or request for payment for such services.

''(B) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1395x(s)(2)(K)(iii) of this title in violation of subparagraph (A) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (s). Pub. L. 103–432, §160(d)(1), redesignated subsec. (r), relating to other prepaid organizations, as (s).

1993—Subsec. (a)(1). Pub. L. 103–66, §13544(b)(2), redesignated subpar. (M) relating to nurse practitioner and clinical nurse specialist services as (O), inserted comma before ''(O)'', transferred and inserted such subpar. to appear before semicolon at end, struck out ''and'' before ''(N)'', and inserted '', and'' and subpar. (P) following subpar. (O) and before semicolon at end.

Subsec. (g). Pub. L. 103–66, §13555(a), substituted ''$900'' for ''$750'' in two places.

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 103–66, §13551(a), added subcl. (IV).

Subsec. (h)(4)(B)(iv) to (vii). Pub. L. 103–66, §13551(b), added cls. (iv) to (vii), and struck out former cl. (iv) which read as follows: ''after December 31, 1990, is equal to 88 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).''

Subsec. (i)(3)(B)(ii). Pub. L. 103–66, §13532(a)(1), in introductory provisions substituted ''paragraph (4)'' for ''the last sentence of this clause'' and struck out concluding provisions which read as follows: ''In the case of a hospital that makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary), receives more than 30 percent of its total revenues from outpatient services and was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987, the cost proportion and ASC proportion in effect under subclauses (I) and (II) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.''

Subsec. (i)(4). Pub. L. 103–66, §13532(a)(2), added par. (4).

Subsec. (*l*)(4)(B)(i). Pub. L. 103–66, §13516(b)(1), inserted ''and before January 1, 1994,'' after ''1991,''.

Subsec. (*l*)(4)(B)(ii). Pub. L. 103–66, §13516(b)(2), inserted ''and'' at end of subcl. (II), substituted a period for the comma at end of subcl. (III), and struck out subcls. (IV) to (VII) which read as follows:

''(IV) for services furnished in 1994, $11.25,

''(V) for services furnished in 1995, $11.50,

''(VI) for services furnished in 1996, $11.70, and

''(VII) for services furnished in calendar years after 1997, the previous year's conversion factor increased by the update determined under section 1395w–4(d)(3) of this title for physician anesthesia services for that year.''

Subsec. (*l*)(4)(B)(iii). Pub. L. 103–66, §13516(b)(3), added cl. (iii).

1990—Subsec. (a)(1)(H). Pub. L. 101–508, §4118(f)(2)(D), struck out '', as the case may be'' after ''section 1395w–4 of this title''.

Subsec. (a)(1)(J). Pub. L. 101–508, §4104(b)(1), struck out ''or physician pathology services'' after ''1395m(b)(6) of this title)'' and ''or section 1395m(f) of this title, respectively'' after ''1395m(b) of this title''.

Subsec. (a)(1)(K). Pub. L. 101–508, §4155(b)(2)(A), which directed amendment of subpar. (K) by striking ''and'' at the end, could not be executed because of prior amendment by Pub. L. 101–508, §4153(a)(2)(B)(i), see below.

Pub. L. 101–508, §4153(a)(2)(B)(i), struck out ''and'' after ''by a physician),''.

Subsec. (a)(1)(L). Pub. L. 101–508, §4153(a)(2)(B)(ii), substituted ''subparagraph,'' for ''subparagraph and'' at end.

Subsec. (a)(1)(M). Pub. L. 101–508, §4155(b)(2)(B), added subpar. (M) relating to nurse practitioner and clinical nurse specialist services.

Pub. L. 101–508, §4153(a)(2)(B)(ii), added subpar. (M) relating to prosthetic devices and orthotics.

Subsec. (a)(2). Pub. L. 101–508, §4153(a)(2)(C)(i), substituted ''(H), and (I)'' for ''and (H)'' in introductory provisions.

Subsec. (a)(2)(E)(i). Pub. L. 101–508, §4163(d)(1), inserted '', but excluding screening mammography'' after ''imaging services''.

Subsec. (a)(7). Pub. L. 101–508, §4153(a)(2)(C)(ii)–(iv), added par. (7).

Subsec. (b). Pub. L. 101–508, §4302, inserted ''for calendar years before 1991 and $100 for 1991 and subsequent years'' after ''$75''.

Subsec. (b)(5). Pub. L. 101–508, §4161(a)(3)(B), added par. (5) at end of first sentence.

Subsec. (h)(2)(A)(ii). Pub. L. 101–508, §4154(a)(1), substituted ''clause (i)'' for ''any other provision of this subsection'' in introductory provisions.

Subsec. (h)(2)(A)(ii)(III). Pub. L. 101–508, §4154(a)(2)–(4), added subcl. (III).

Subsec. (h)(4)(B). Pub. L. 101–508, §4154(b)(1)(B), struck out ''and'' at end of cl. (ii), inserted ''and before January 1, 1991,'' after ''1989,'' in cl. (iii), substituted '', and'' for period at end of cl. (iii), and added cl. (iv).

Subsec. (h)(5)(A)(ii)(II). Pub. L. 101–508, §4154(e)(1)(A), substituted ''wholly owned by'' for ''a wholly-owned subsidiary of''.

Subsec. (h)(5)(A)(ii)(III). Pub. L. 101–508, §4154(e)(1)(C), substituted ''receives requests for testing during the year in which the test is performed'' for ''submits bills or requests for payment in any year''.

Pub. L. 101–508, §4154(e)(1)(B), which directed substitution of ''laboratory (but not including a laboratory described in subclause (II))'' for ''laboratory'', was executed by making the substitution for ''laboratory'' the second time appearing to reflect the probable intent of Congress.

Subsec. (h)(5)(A)(iii). Pub. L. 101–508, §4008(m)(2)(C), which directed technical correction to Pub. L. 101–239,

§ 6003(g)(3)(C)(vii)(I), was executed by making technical correction to Pub. L. 101–239, § 6003(g)(3)(D)(vii)(I), resulting in no change in text. See 1989 Amendment note below.

Subsec. (h)(5)(C). Pub. L. 101–508, § 4154(c)(1)(A), substituted ''test, including a test performed in a physician's office but excluding a test performed by a rural health clinic'' for ''test performed by a laboratory other than a rural health clinic''.

Subsec. (h)(5)(D). Pub. L. 101–508, § 4154(c)(1)(B), substituted ''test, including a test performed in a physician's office but excluding a test performed by a rural health clinic,'' for ''test performed by a laboratory, other than a rural health clinic''.

Subsec. (i)(3)(B)(ii). Pub. L. 101–508, § 4151(c)(1)(B), substituted ''on or after October 1, 1988, and before January 1, 1995'' for ''in fiscal year 1989 or fiscal year 1990'' in last sentence.

Subsec. (i)(3)(B)(ii)(I). Pub. L. 101–508, § 4151(c)(1)(A)(i), substituted ''50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991'' for ''and 50 percent for other cost reporting periods''.

Subsec. (i)(3)(B)(ii)(II). Pub. L. 101–508, § 4151(c)(1)(A)(ii), substituted ''50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991'' for ''and 50 percent for other cost reporting periods''.

Subsec. (*l*)(1). Pub. L. 101–508, § 4160(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (*l*)(2). Pub. L. 101–508, § 4160(2), struck out at end ''The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for that year.''

Subsec. (*l*)(4). Pub. L. 101–508, § 4160(3), added par. (4) and struck out former par. (4) which read as follows: ''In establishing the fee schedule under paragraph (1), the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology. The Secretary may establish a nationwide fee schedule or adjust the fee schedule for geographic areas (as the Secretary may determine to be appropriate).''

Subsec. (m). Pub. L. 101–597 substituted ''health professional shortage area'' for ''health manpower shortage area''.

Subsec. (n)(1)(B)(ii)(I). Pub. L. 101–508, § 4151(c)(2), inserted before period at end '', and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991''.

Subsec. (r). Pub. L. 101–508, § 4206(b)(2), added subsec. (r) relating to other prepaid organizations.

Pub. L. 101–508, § 4155(b)(3), added subsec. (r) relating to cap on prevailing charge and billing on assignment-related basis.

1989—Subsec. (a). Pub. L. 101–234, § 202(a), repealed Pub. L. 100–360, § 212(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 205(c)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(F). Pub. L. 101–239, § 6113(b)(3)(A), added subpar. (F).

Subsec. (a)(1)(H). Pub. L. 101–239, § 6102(e)(5), inserted ''(or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title, as the case may be)'' after ''prevailing charge that would be recognized''.

Subsec. (a)(1)(J). Pub. L. 101–239, § 6102(f)(2), inserted ''or physician pathology services'' after ''1395m(b)(6) of this title)'' and ''or section 1395m(f) of this title, respectively'' after ''1395m(b) of this title''.

Pub. L. 101–239, § 6102(e)(6)(A), inserted ''subject to section 1395w–4 of this title,'' before ''the amounts''.

Subsec. (a)(1)(K). Pub. L. 101–239, § 6102(e)(7), inserted '', or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1395w–4 of this title for the same service performed by a physician'' after ''for the same service performed by a physician''.

Subsec. (a)(1)(M). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 201(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(N). Pub. L. 101–239, § 6102(e)(1)(B), added subpar. (N).

Subsec. (a)(2). Pub. L. 101–239, § 6116(b)(1)(A), substituted ''(G), and (H)'' for ''and (G)'' in introductory provisions.

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, §§ 202(b)(2), 203(c)(1)(A)–(D), 204(d)(1), and 205(c)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(3). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 205(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(6). Pub. L. 101–239, § 6116(b)(1)(B)–(D), added par. (6).

Subsec. (b). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, §§ 202(b)(3), 203(c)(1)(E), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (c). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 201(a)(1), (4), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (d). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 201(a)(1)(D), (2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (d)(1). Pub. L. 101–239, § 6113(d), substituted ''62½ percent of such expenses.'' for ''whichever of the following amounts is the smaller:

''(A) $1375.00, or

''(B) 62½ percent of such expenses.''

Subsec. (g). Pub. L. 101–239, § 6133(a), substituted ''$750'' for ''$500'' in two places.

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 201(a)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (h)(1)(B), (C). Pub. L. 101–239, § 6111(a)(1), substituted ''on or after July 1, 1984'' for ''during the period beginning on July 1, 1984, and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis.''

Subsec. (h)(1)(D). Pub. L. 101–239, § 6003(e)(2)(A), substituted ''section 1395ww(d)(5)(D)(iii) of this title'' for ''the last sentence of section 1395ww(d)(5)(C)(ii) of this title''.

Subsec. (h)(4)(B)(ii). Pub. L. 101–239, § 6111(a)(3)(A), (B), substituted ''after March 31, 1988, and before January 1, 1990,'' for ''after March 31, 1988, and so long as a fee schedule for the test has not been established on a nationwide basis,''.

Subsec. (h)(4)(B)(iii). Pub. L. 101–239, § 6111(a)(2), (3)(C), (4), added cl. (iii).

Subsec. (h)(5)(A)(ii). Pub. L. 101–239, § 6111(b)(1), substituted ''referring laboratory but only if—'' for ''referring laboratory, and'' in introductory provisions, and added subcls. (I) through (III).

Subsec. (h)(5)(A)(iii). Pub. L. 101–239, § 6003(g)(3)(D)(vii)(I), as amended by Pub. L. 101–508,

§ 4008(m)(2)(C), substituted ''hospital or rural primary care hospital,'' for ''hospital,''.

Subsec. (i)(1)(A). Pub. L. 101–239, § 6003(g)(3)(D)(vii)(II), inserted '', rural primary care hospital,'' after ''section 1395k(a)(2)(F)(i) of this title)''.

Subsec. (i)(3)(A). Pub. L. 101–239, § 6003(g)(3)(D)(vii)(III), inserted ''or rural primary care hospital services'' after ''facility services'' in introductory provisions.

Subsec. (*l*)(5)(A). Pub. L. 101–239, § 6003(g)(3)(D)(vii)(IV), inserted ''rural primary care hospital,'' after ''hospital,'' in two places.

Subsec. (*l*)(5)(C). Pub. L. 101–239, § 6003(g)(3)(D)(vii)(V), substituted ''hospital or rural primary care hospital'' for ''hospital'' in two places.

Subsec. (m). Pub. L. 101–239, § 6102(c)(1), struck out ''class 1 or class 2'' before ''health manpower shortage area'' and substituted ''10 percent'' for ''5 percent''.

Subsec. (*o*)(1). Pub. L. 101–239, § 6131(a)(1)(C), inserted ''(or inserts)'' after ''shoes'' in two places in last sentence.

Subsec. (*o*)(1)(A). Pub. L. 101–239, § 6131(a)(1)(A), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''no payment may be made under this part for the furnishing of more than one pair of shoes for any individual for any calendar year, and''.

Subsec. (*o*)(1)(B), (2)(A). Pub. L. 101–239, § 6131(a)(1)(B), substituted ''limits'' for ''limit''.

Subsec. (*o*)(2)(A)(i). Pub. L. 101–239, § 6131(a)(1)(D), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: ''for the furnishing of one pair of custom molded shoes is $300''.

Subsec. (*o*)(2)(A)(ii)(II). Pub. L. 101–239, § 6131(a)(1)(E), inserted ''any pairs of'' after ''$50 for''.

Subsec. (*o*)(2)(D). Pub. L. 101–239, § 6131(b), added subpar. (D).

Subsec. (p). Pub. L. 101–239, § 6113(b)(3)(B), substituted ''1395x(s)(2)(L) of this title,'' for ''1395x(s)(2)(L) of this title and'' and inserted ''and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1395x(s)(2)(N) of this title,'' after ''section 1395x(s)(2)(M) of this title,''.

Subsec. (q). Pub. L. 101–239, § 6204(b), added subsec. (q).

1988—Subsec. (a). Pub. L. 100–360, § 212(c)(2), inserted ''or, as provided in section 1395t–1(c) of this title, from the Federal Catastrophic Drug Insurance Trust Fund'' after ''Fund'' in introductory provisions.

Pub. L. 100–360, § 205(c)(3), inserted provision at end relating to payment for in-home care for chronically dependent individuals.

Subsec. (a)(1)(D)(i). Pub. L. 100–360, § 411(i)(4)(C)(i), amended Pub. L. 100–203, § 4085(i)(1)(A), see 1987 Amendment note below.

Subsec. (a)(1)(F). Pub. L. 100–360, § 411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, § 4055(a)(1), see 1987 Amendment note below.

Pub. L. 100–360, § 411(i)(4)(C)(iv), made technical amendment to directory language of Pub. L. 100–203, § 4085(i)(21)(D)(i), see 1987 Amendment note below.

Pub. L. 100–360, § 411(i)(4)(C)(ii), repealed Pub. L. 100–203, § 4085(i)(1)(B), see 1987 Amendment note below.

Pub. L. 100–360, § 411(h)(4)(B)(i), (ii), redesignated and amended directory language of Pub. L. 100–203, § 4073(b)(1)(A), see 1987 Amendment note below.

Subsec. (a)(1)(G). Pub. L. 100–360, § 411(h)(7)(C)(ii), repealed Pub. L. 100–203, § 4077(b)(3)(A), see 1987 Amendment note below.

Pub. L. 100–360, § 411(h)(4)(B)(iii), repealed Pub. L. 100–203, § 4073(b)(2)(B), see 1987 Amendment note below.

Subsec. (a)(1)(H). Pub. L. 100–360, § 411(h)(7)(C)(ii), repealed Pub. L. 100–203, § 4077(b)(3)(B), see 1987 Amendment note below.

Pub. L. 100–360, § 411(g)(1)(E), which directed the amendment of subpar. (H) by striking ''and'' before ''(I)'' could not be executed because of the prior amendment by section 4049(a)(1) of Pub. L. 100–203, see 1987 Amendment note below.

Pub. L. 100–360, § 411(i)(3), added Pub. L. 100–203, § 4084(c)(2), see 1987 Amendment note below.

Subsec. (a)(1)(J). Pub. L. 100–360, § 411(f)(8)(B)(i), made technical amendment to directory language of Pub. L. 100–203, § 4049(a)(1), see 1987 Amendment note below.

Pub. L. 100–360, § 411(f)(8)(C), substituted ''section 1395m(b)(6) of this title'' for ''section 1395m(b)(5) of this title''.

Subsec. (a)(1)(K). Pub. L. 100–360, § 411(h)(7)(C)(iii), (F), redesignated and amended Pub. L. 100–203, § 4077(b)(2)(A), see 1987 Amendment note below.

Pub. L. 100–360, § 411(h)(4)(B)(i), (iv), (v), redesignated and amended Pub. L. 100–203, § 4073(b)(1)(B), see 1987 Amendment note below.

Subsec. (a)(1)(L). Pub. L. 100–360, § 411(h)(7)(C)(i), (iv), (v), (F), redesignated and amended Pub. L. 100–203, § 4077(b)(2)(B), see 1987 Amendment note below.

Subsec. (a)(1)(M). Pub. L. 100–360, § 202(b)(1), added subpar. (M) relating to expenses incurred for covered outpatient drugs.

Subsec. (a)(2). Pub. L. 100–360, § 205(c)(1), inserted ''(A)(ii),'' after ''subparagraphs'' in introductory provisions.

Pub. L. 100–360, § 202(b)(2), inserted ''(other than covered outpatient drugs)'' after ''in the case of services'' in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 100–360, § 203(c)(1)(A), substituted ''(E), or (F)'' for ''or (E)'' in introductory provisions.

Subsec. (a)(2)(D)(i). Pub. L. 100–360, § 411(i)(4)(C)(i), amended Pub. L. 100–203, § 4085(i)(1)(A), see 1987 Amendment note below.

Subsec. (a)(2)(E)(i). Pub. L. 100–360, § 204(d)(1), inserted '', but excluding screening mammography'' after ''imaging services''.

Subsec. (a)(2)(F). Pub. L. 100–360, § 203(c)(1)(B)–(D), added subpar. (F) relating to home intravenous drug therapy services.

Subsec. (a)(3). Pub. L. 100–360, § 205(c)(2), substituted ''subparagraphs (A)(ii), (D),'' for ''subparagraphs (D)''.

Subsec. (b). Pub. L. 100–360, § 104(d)(7), as added by Pub. L. 100–485, § 608(d)(3)(G), inserted at end ''The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1395e(a)(2) of this title to blood or blood cells furnished the individual in the year.''

Subsec. (b)(1). Pub. L. 100–360, § 202(b)(3)(A), inserted ''or for covered outpatient drugs'' after ''section 1395x(s)(10)(A) of this title''.

Subsec. (b)(2). Pub. L. 100–360, § 203(c)(1)(E), substituted ''services and home intravenous drug therapy services'' for ''services''.

Pub. L. 100–360, § 202(b)(3)(B), inserted ''or with respect to covered outpatient drugs'' after ''home health services''.

Subsec. (b)(3) to (5). Pub. L. 100–360, § 411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, § 4055(a)(2), see 1987 Amendment note below.

Subsec. (c). Pub. L. 100–360, § 201(a)(4), added subsec. (c) relating to limitation on out-of-pocket catastrophic cost-sharing, adjustment, buy-out plans, and conditions for payments with respect to plans other than buy-out plans. Former subsec. (c) redesignated (d)(1).

Pub. L. 100–360, § 411(h)(1)(A), substituted ''monitoring or changing drug prescriptions'' for ''prescribing or monitoring prescription drugs'' in last sentence.

Pub. L. 100–360, § 201(a)(1)(A), as amended by Pub. L. 100–485, § 608(d)(4), substituted ''subsections (a) through (c)'' for ''subsections (a) and (b)'' in introductory provisions.

Pub. L. 100–360, § 201(a)(1)(B), (C), redesignated former pars. (1) and (2) as subpars. (A) and (B) and substituted ''this paragraph'' for ''this subsection'' in last sentence.

Subsec. (d)(1). Pub. L. 100–360, § 201(a)(1)(D), redesignated former subsec. (c) as subsec. (d)(1). Former subsec. (d) redesignated subsec. (d)(2).

Subsec. (d)(2). Pub. L. 100–360, § 201(a)(2), redesignated former subsec. (d) as subsec. (d)(2).

Subsec. (f). Pub. L. 100–360, § 411(g)(5), substituted ''MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section

1395u(i)(4) of this title)'' for ''medicare economic index (referred to in the fourth sentence of section 1395u(b)(3) of this title) applicable to physicians' services''.

Subsec. (g). Pub. L. 100–360, §201(a)(3), substituted ''subsections (a) through (c) of this section'' for ''subsections (a) and (b) of this section'' in two places.

Subsec. (h)(1)(D). Pub. L. 100–360, §411(g)(3)(E), (F), amended and redesignated Pub. L. 100–203, §4064(c)(1), see 1987 Amendment note below.

Subsec. (h)(2)(A)(i). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(1), see 1987 Amendment note below.

Subsec. (h)(2)(A)(ii). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(3), see 1987 Amendment note below.

Subsec. (h)(2)(A)(iii). Pub. L. 100–360, §411(g)(3)(B), (C), amended Pub. L. 100–203, §4064(b)(1), see 1987 Amendment note below.

Subsec. (h)(2)(B). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(2), see 1987 Amendment note below.

Subsec. (h)(3). Pub. L. 100–647, §8421(a), inserted at end ''In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this subchapter for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.''

Subsec. (h)(4)(B)(ii). Pub. L. 100–360, §411(g)(3)(D), inserted ''after'' before ''March 31, 1988''.

Subsec. (h)(5)(A). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(B), see 1987 Amendment note below.

Subsec. (h)(5)(C). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(B), see 1987 Amendment note below.

Subsec. (h)(5)(D). Pub. L. 100–360, §411(i)(4)(B), substituted ''A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence'' for ''If a person knowingly and willfully and on a repeated basis bills an individual enrolled under this part for charges for a clinical diagnostic laboratory test for which payment may only be made on an assignment-related basis under subparagraph (C)'' and ''paragraphs (2) and (3) of section 1395u(j) of this title in the same manner such paragraphs apply with respect to a physician'' for ''section 1395u(j)(2) of this title''.

Subsec. (i)(2)(A)(iii). Pub. L. 100–360, §411(g)(2)(D), substituted ''insertion'' for ''implantation'' and inserted ''or subsequent to'' after ''during''.

Subsec. (i)(4). Pub. L. 100–360, §411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, §4055(a)(3), see 1987 Amendment note below.

Subsec. (i)(6). Pub. L. 100–485, §608(d)(22)(B), substituted ''Any person, including'' for ''Any person, other than''.

Pub. L. 100–360, §411(g)(2)(E), added Pub. L. 100–203, §4063(e)(1), see 1987 Amendment note below.

Subsec. (*l*)(2). Pub. L. 100–360, §411(f)(2)(D), added Pub. L. 100–203, §4042(b)(2)(B), see 1987 Amendment note below.

Subsec. (*l*)(3)(B). Pub. L. 100–647, §8422(a), inserted ''plus applicable coinsurance'' after ''would have been paid''.

Subsec. (*l*)(5)(B)(ii). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(23), see 1987 Amendment note below.

Subsec. (n)(1)(A). Pub. L. 100–360, §411(g)(4)(C)(i), as amended by Pub. L. 100–485, §608(d)(22)(D), substituted ''for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989,'' for ''beginning on or after October 1, 1988 under this part for services described in subsection (a)(2)(E)'' in introductory provisions.

Subsec. (n)(1)(B)(i)(II). Pub. L. 100–360, §411(g)(4)(C)(ii), inserted ''or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established'' after ''the prevailing charge''.

Subsec. (n)(1)(B)(ii). Pub. L. 100–360, §411(g)(4)(C)(iii), amended subcls. (I) and (II) generally. Prior to amendment, subcls. (I) and (II) read as follows:

''(I) The term 'cost proportion' means 65 percent for all or any part of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods.

''(II) The term 'charge proportion' means 35 percent for all or any parts of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods.''

Subsec. (*o*). Pub. L. 100–360, §411(h)(3)(B), as amended by Pub. L. 100–485, §608(d)(23)(A), amended Pub. L. 100–203, §4072(b), see 1987 Amendment note below.

Subsec. (p). Pub. L. 100–360, §411(h)(7)(D), (F), redesignated and amended Pub. L. 100–203, §4077(b)(3), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(C), redesignated and amended Pub. L. 100–203, §4073(b)(2), see 1987 Amendment note below.

1987—Subsec. (a)(1)(D)(i). Pub. L. 100–203, §4085(i)(1)(A), as amended by Pub. L. 100–360, §411(i)(4)(C)(i), substituted ''on an assignment-related basis,'' for ''on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title,''.

Subsec. (a)(1)(F). Pub. L. 100–203, §4055(a)(1), formerly §4054(a)(1), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), struck out subpar. (F) which read as follows: ''with respect to expenses incurred for services described in subsection (i)(4) of this section under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,''.

Pub. L. 100–203, §4085(i)(21)(D)(i), as amended by Pub. L. 100–360, §411(i)(4)(C)(iv), amended Pub. L. 99–509, §9343(e)(2)(A), see 1986 Amendment note below.

Pub. L. 100–203, §4085(i)(1)(B), which directed striking out ''and'' at end, was repealed by Pub. L. 100–360, §411(i)(4)(C)(ii).

Pub. L. 100–203, §4073(b)(1)(A), formerly §4073(b)(2)(A), as redesignated and amended by Pub. L. 100–360, §411(h)(4)(B)(i), (ii), struck out ''and'' at end.

Subsec. (a)(1)(G). Pub. L. 100–203, §4077(b)(3)(A), which directed striking out ''and'' at end, was repealed by Pub. L. 100–360, §411(h)(7)(C)(ii).

Pub. L. 100–203, §4073(b)(2)(B), which directed substituting ''services,'' for ''services; and'', was repealed by Pub. L. 100–360, §411(h)(4)(B)(iii).

Pub. L. 100–203, §4062(d)(3)(A)(i), substituted ''services,'' for ''services; and''.

Subsec. (a)(1)(H). Pub. L. 100–203, §4077(b)(3)(B), which directed substituting ''services,'' for ''services; and'', was repealed by Pub. L. 100–360, §411(h)(7)(C)(ii).

Pub. L. 100–203, §4084(c)(2), as added by Pub. L. 100–360, §411(i)(3), substituted ''least of the actual charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist,'' for ''lesser of the actual charge''.

Pub. L. 100–203, §4062(d)(3)(A)(ii), inserted ''and'' before the subpar. (I) added by section 4062(d)(3)(A)(ii) of Pub. L. 100–203, see below.

Pub. L. 100–203, § 4049(a)(1), struck out ''and'' before the subpar. (I) added by section 4062(d)(3)(A)(ii) of Pub. L. 100–203, see below.

Subsec. (a)(1)(I). Pub. L. 100–203, § 4062(d)(3)(A)(ii), added subpar. (I).

Subsec. (a)(1)(J). Pub. L. 100–203, § 4049(a)(1), as amended by Pub. L. 100–360, § 411(f)(8)(B)(i), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 100–203, § 4077(b)(2)(A), formerly § 4077(b)(3)(C), as redesignated and amended by Pub. L. 100–360, § 411(h)(7)(C)(iii), (F), inserted ''and'' after ''performed by a physician),''.

Pub. L. 100–203, § 4073(b)(1)(B), formerly § 4073(b)(2)(C), as redesignated and amended by Pub. L. 100–360, § 411(h)(4)(B)(i), (iv), (v), added subpar. (K), formerly (I), relating to amounts paid with respect to certified nurse-midwife services under section 1395x(s)(2)(L) of this title.

Subsec. (a)(1)(L). Pub. L. 100–203, § 4077(b)(2)(B), formerly § 4077(b)(3)(D), as redesignated and amended by Pub. L. 100–360, § 411(h)(7)(C)(i), (iv), (v), (F), added subpar. (L), formerly (J), relating to amounts paid with respect to qualified psychologist services under section 1395x(s)(2)(M) of this title.

Subsec. (a)(2). Pub. L. 100–203, § 4062(d)(3)(B)(i), inserted reference to subpar. (G).

Subsec. (a)(2)(A). Pub. L. 100–203, § 4062(d)(3)(B)(ii), struck out ''(other than durable medical equipment)'' after ''home health services''.

Subsec. (a)(2)(B). Pub. L. 100–203, § 4066(b), inserted reference to subpar. (E).

Subsec. (a)(2)(D)(i). Pub. L. 100–203, § 4085(i)(1)(A), as amended by Pub. L. 100–360, § 411(i)(4)(C)(i), substituted ''on an assignment-related basis,'' for ''on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title,''.

Subsec. (a)(2)(E). Pub. L. 100–203, § 4066(a)(1), added subpar. (E).

Subsec. (a)(5). Pub. L. 100–203, § 4062(d)(3)(C)–(E), added par. (5).

Subsec. (b)(3). Pub. L. 100–203, § 4055(a)(2), formerly § 4054(a)(2), as added and renumbered by Pub. L. 100–360, § 411(f)(12)(A), (14), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: ''such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(F) of this section,''.

Pub. L. 100–203, § 4085(i)(21)(D)(i), amended Pub. L. 99–509, § 9343(e)(2)(A), see 1986 Amendment note below.

Subsec. (b)(4). Pub. L. 100–203, § 4055(a)(2), formerly § 4054(a)(2), as added and renumbered by Pub. L. 100–360, § 411(f)(12)(A), (14), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (b)(4)(A). Pub. L. 100–203, § 4085(i)(1)(C), substituted ''on an assignment-related basis'' for ''on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title''.

Subsec. (b)(5). Pub. L. 100–203, § 4055(a)(2), formerly § 4054(a)(2), as added and renumbered by Pub. L. 100–360, § 411(f)(12)(A), (14), redesignated par. (5) as (4).

Subsec. (c). Pub. L. 100–203, § 4070(b)(4), inserted ''or partial hospitalization services that are not directly provided by a physician'' before period at end of last sentence.

Pub. L. 100–203, § 4070(a)(2), inserted sentence at end defining ''treatment''.

Subsec. (c)(1). Pub. L. 100–203, § 4070(a)(1), substituted ''$1375.00'' for ''$312.50''.

Subsec. (f). Pub. L. 100–203, § 4067(a), added subsec. (f).

Subsec. (h)(1)(C). Pub. L. 100–203, § 4085(i)(2), inserted before period at end '', and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis''.

Subsec. (h)(1)(D). Pub. L. 100–203, § 4064(c)(1), formerly § 4064(c), as amended and redesignated by Pub. L. 100–360, § 411(g)(3)(E), (F), inserted '', in a sole community hospital (as defined in the last sentence of section 1395ww(d)(5)(C)(ii) of this title),''.

Subsec. (h)(2). Pub. L. 100–203, § 4064(c), which had directed that ''laboratory in a sole community hospital'' be substituted for ''hospital laboratory'' in subsec. (h)(2), was redesignated § 4064(c)(1) by section 411(g)(3)(F) of Pub. L. 100–360 and amended by section 411(g)(3)(E) of Pub. L. 100–360 to provide for amendment of subsec. (h)(1)(D) instead of subsec. (h)(2).

Subsec. (h)(2)(A)(i). Pub. L. 100–203, § 4064(a)(1), as added by Pub. L. 100–360, § 411(g)(3)(A), inserted ''(A)(i)'' after ''(2)''.

Subsec. (h)(2)(A)(ii). Pub. L. 100–203, § 4064(a)(3), as added by Pub. L. 100–360, § 411(g)(3)(A), added cl. (ii).

Subsec. (h)(2)(A)(iii). Pub. L. 100–203, § 4064(b)(1), as amended by Pub. L. 100–360, § 411(g)(3)(B), (C), set out as cl. (iii) provisions formerly set out in an otherwise undesignated sentence in par. (2) relating to the rebasing of fee schedules for certain automated and similar tests for 1988 and for the continuation of such reduced fee schedules as the base for 1989 and subsequent years.

Subsec. (h)(2)(B). Pub. L. 100–203, § 4064(a)(2), as added by Pub. L. 100–360, § 411(g)(3)(A), inserted subpar. (B) designation preceding second sentence and redesignated former subpars. (A) and (B) of par. (2) as cls. (i) and (ii).

Subsec. (h)(4)(B)(i). Pub. L. 100–203, § 4064(b)(2)(A), substituted ''April'' for ''January''.

Subsec. (h)(4)(B)(ii). Pub. L. 100–203, § 4064(b)(2)(B), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''after December 31, 1987, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).''

Subsec. (h)(5)(A). Pub. L. 100–203, § 4085(i)(22)(B), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''on an assignment-related basis'' for ''on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title,'' in introductory provisions.

Subsec. (h)(5)(A)(iii). Pub. L. 100–203, § 4085(i)(3), added cl. (iii).

Subsec. (h)(5)(C). Pub. L. 100–203, § 4085(i)(22)(B), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''on an assignment-related basis'' for ''on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, in accordance with section 1395u(b)(6)(B) of this title, under the procedure described in section 1395gg(f)(1) of this title,''.

Subsec. (h)(5)(D). Pub. L. 100–203, § 4085(b)(1), added subpar. (D).

Subsec. (i)(2)(A)(iii). Pub. L. 100–203, § 4063(b), added cl. (iii).

Subsec. (i)(3)(B)(ii). Pub. L. 100–203, § 4068(a)(1), substituted ''Subject to the last sentence of this clause, in'' for ''In''.

Pub. L. 100–203, § 4068(a)(2), inserted sentence at end relating to cost and ASC proportions in the case of an eye or eye and ear specialty hospital.

Subsec. (i)(4). Pub. L. 100–203, § 4055(a)(3), formerly § 4054(a)(3), as added and renumbered by Pub. L. 100–360, § 411(f)(12)(A), (14), struck out par. (4) which read as follows: ''In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1395x(s) of this title and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(F) of this section if the physician accepts an assignment described in section 1395u(b)(3)(B)(ii) of this title with respect to payment for such services.''

Subsec. (i)(6). Pub. L. 100–203, § 4063(e)(1), as added by Pub. L. 100–360, § 411(g)(2)(E), added par. (6).

Subsec. (*l*)(2). Pub. L. 100–203, § 4084(a)(1), substituted ''1985 and such other data as the Secretary determines necessary'' for ''1985''.

Pub. L. 100–203, § 4042(b)(2)(B), as added by Pub. L. 100–360, § 411(f)(2)(D), substituted ''1395u(i)(3)'' for ''1395u(b)(4)(E)(ii)''.

Subsec. (*l*)(5)(A). Pub. L. 100–203, §4084(a)(2), substituted ''group practice, or ambulatory surgical center'' for ''or group practice'' in two places.

Subsec. (*l*)(5)(B)(ii). Pub. L. 100–203, §4085(i)(23), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted ''money penalty'' for ''monetary penalty'' and amended second sentence generally. Prior to amendment, second sentence read as follows: ''Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section.''

Subsec. (*l*)(6). Pub. L. 100–203, §4045(c)(2)(A)(i), (ii), struck out subpar. (A) designation and substituted ''after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1395u(j)(1)(D) of this title.'' for ''(subject to subparagraph (D)), the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.''

Pub. L. 100–203, §4045(c)(2)(A)(iii), struck out subpars. (B) to (D) which read as follows:

''(B) In subparagraph (A), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in subparagraph (A).

''(C) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) of this section.

''(D) This paragraph shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title.''

Subsec. (m). Pub. L. 100–203, §4043(a), added subsec. (m).

Subsec. (n). Pub. L. 100–203, §4066(a)(2), added subsec. (n).

Subsec. (*o*). Pub. L. 100–203, §4072(b), as amended by Pub. L. 100–360, §411(h)(3)(B), as amended by Pub. L. 100–485, §608(d)(23)(A), added subsec. (*o*) [originally added as subsec. (f)].

Subsec. (p). Pub. L. 100–203, §4077(b)(3), formerly §4077(b)(4), as redesignated and amended by Pub. L. 100–360, §411(h)(7)(D), (F), inserted ''and in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1395x(s)(2)(M) of this title''.

Pub. L. 100–203, §4073(b)(2), formerly §4073(b)(3), as redesignated and amended by Pub. L. 100–360, §411(h)(4)(C), added subsec. (p) [originally added as subsec. (m)] and inserted provision relating to monetary penalty for whoever knowingly and willfully presents, or causes to be presented, to an enrolled individual a bill or request for payment for described services.

1986—Subsec. (a)(1)(D). Pub. L. 99–272, §9401(b)(2)(B), substituted '', under the procedure described in section 1395gg(f)(1) of this title, or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)'' for ''or under the procedure described in section 1395gg(f)(1) of this title''.

Subsec. (a)(1)(D)(i). Pub. L. 99–272, §9303(b)(1), inserted '', the limitation amount for that test determined under subsection (h)(4)(B),'' after ''lesser of the amount determined under such fee schedule''.

Subsec. (a)(1)(F). Pub. L. 99–509, §9343(e)(2)(A), as amended by Pub. L. 100–203, §4085(i)(21)(D)(i), substituted ''(i)(4)'' for ''(i)(3)''.

Subsec. (a)(1)(G). Pub. L. 99–272, §9401(b)(2)(A), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 99–509, §9320(e)(1), added subpar. (H).

Subsec. (a)(2)(A). Pub. L. 99–272, §9401(b)(2)(C), inserted '', to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),'' after ''(other than durable medical equipment)''.

Subsec. (a)(2)(D). Pub. L. 99–272, §9401(b)(2)(D), substituted ''to a provider having an agreement under section 1395cc of this title, or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)'' for ''or to a provider having an agreement under section 1395cc of this title''.

Subsec. (a)(2)(D)(i). Pub. L. 99–272, §9303(b)(1), inserted '', the limitation amount for that test determined under subsection (h)(4)(B),'' after ''lesser of the amount determined under such fee schedule''.

Subsec. (a)(3). Pub. L. 99–272, §9401(b)(2)(E), inserted ''and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion'' after ''1395x(s)(10)(A) of this title''.

Subsec. (a)(4). Pub. L. 99–509, §9343(a)(1)(A), amended par. (4) generally. Prior to amendment, par. (4) read as follows: ''in the case of facility services described in subparagraph (F) of section 1395k(a)(2) of this title, the applicable amount described in paragraph (2) of subsection (i) of this section.''

Subsec. (b)(3). Pub. L. 99–509, §9343(e)(2)(A), as amended by Pub. L. 100–203, §4085(i)(21)(D)(i), which directed that par. (3) be amended by striking ''or under subsection (i)(2) or (i)(4) of this section'', was executed by striking ''or under subsection (i)(2) or (i)(5) of this section'', to reflect the probable intent of Congress and an earlier amendment by Pub. L. 99–509, §9343(a)(2), see below.

Pub. L. 99–509, §9343(a)(2), substituted ''(i)(5)'' for ''(i)(4)''.

Subsec. (b)(5). Pub. L. 99–272, §9401(b)(1), added par. (5).

Subsec. (g). Pub. L. 99–509, §9337(b), substituted ''second sentence'' for ''next to last sentence'', and inserted at end ''In the case of outpatient occupational therapy services which are described in the second sentence of section 1395x(p) of this title through the operation of section 1395x(g) of this title, with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).''

Subsec. (h)(1)(B). Pub. L. 99–509, §9339(b)(1), substituted ''December 31, 1989'' and ''January 1, 1990'' for ''December 31, 1987'' and ''January 1, 1988'', respectively.

Pub. L. 99–509, §9339(a)(1)(A), substituted ''qualified hospital laboratory (as defined in subparagraph (D))'' for ''hospital laboratory''.

Pub. L. 99–272, §9303(a)(1)(A), substituted ''December 31, 1987'' for ''June 30, 1987'' and ''January 1, 1988'' for ''July 1, 1987''.

Subsec. (h)(1)(C). Pub. L. 99–509, §9339(a)(1)(B), substituted ''qualified hospital laboratory (as defined in subparagraph (D))'' for ''hospital laboratory'', struck out '', and ending on December 31, 1987'' after ''July 1, 1984'', and struck out ''For such tests furnished on or after January 1, 1988, the fee schedule under subparagraph (A) shall not apply with respect to clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital.'' which constituted second sentence.

Pub. L. 99–272, §9303(a)(1)(A), substituted ''December 31, 1987'' for ''June 30, 1987'' and ''January 1, 1988'' for ''July 1, 1987''.

Subsec. (h)(1)(D). Pub. L. 99–509, §9339(a)(1)(C), added subpar. (D).

Subsec. (h)(2). Pub. L. 99–509, §9339(b)(2), struck out ''(or, effective January 1, 1988, for the United States)'' after ''applicable region, State, or area''.

Pub. L. 99–509, §9339(a)(1)(D), substituted ''qualified hospital laboratory (as defined in paragraph (1)(D))'' for ''hospital laboratory''.

Pub. L. 99–272, §9303(a)(1), substituted ''January 1, 1988'' for ''July 1, 1987'', and inserted ''(to become effective on January 1 of each year)'' after ''adjusted annually''.

Subsec. (h)(3). Pub. L. 99–509, §9339(c)(1), inserted subpar. (A) designation after ''provide for and establish'', and added subpar. (B).

Subsec. (h)(4). Pub. L. 99–272, §9303(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (h)(5)(C). Pub. L. 99–272, §9303(b)(3), substituted ''laboratory other than'' for ''laboratory which is independent of a physician's office or''.

Subsec. (i)(1). Pub. L. 99–509, §9343(b)(2), inserted at end ''The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.''

Subsec. (i)(2). Pub. L. 99–509, §9343(e)(2)(B), inserted ''80 percent of'' before ''a standard overhead amount'' in introductory provisions of subpars. (A) and (B).

Pub. L. 99–509, §9343(b)(1), substituted ''shall be reviewed and updated not later than July 1, 1987, and annually thereafter'' for ''shall be reviewed periodically'' in concluding provisions of subpars. (A) and (B).

Subsec. (i)(3) to (5). Pub. L. 99–509, §9343(a)(1)(B), added par. (3) and redesignated former pars. (3) and (4) as (4) and (5), respectively.

Subsec. (*l*). Pub. L. 99–509, §9320(e)(2), added subsec. (*l*).

1984—Subsec. (a)(1). Pub. L. 98–369, §2354(b)(7), struck out ''and'' at the end.

Subsec. (a)(1)(B). Pub. L. 98–369, §2323(b)(1), substituted ''section 1395x(s)(10)(A) of this title'' for ''section 1395x(s)(10) of this title''.

Subsec. (a)(1)(D). Pub. L. 98–369, §2303(a), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: ''with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (h) of this section),''.

Subsec. (a)(1)(F), (G). Pub. L. 98–369, §2305(a), redesignated subpar. (G) as (F), and struck out former subpar. (F) which related to payment of reasonable charges for preadmission diagnostic services furnished by a physician to individuals enrolled under this part which are furnished in the outpatient department of a hospital within seven days of such individual's admission to the same hospital or another hospital or furnished in the physician's office within seven days of such individual's admission to a hospital as an inpatient.

Subsec. (a)(2). Pub. L. 98–369, §2305(c), struck out ''and in paragraph (5) of this subsection'' after ''of such section''.

Subsec. (a)(2)(A). Pub. L. 98–617, §3(b)(2), inserted '', or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision),''.

Pub. L. 98–369, §2354(b)(5), realigned margin of subpar. (A).

Pub. L. 98–369, §2321(b)(1), inserted in provision preceding cl. (i) ''(other than durable medical equipment)''.

Pub. L. 98–369, §2323(b)(1), substituted ''section 1395x(s)(10)(A) of this title'' for ''section 1395x(s)(10) of this title''.

Subsec. (a)(2)(B). Pub. L. 98–369, §2354(b)(5), realigned margin of subpar. (B).

Pub. L. 98–369, §2321(b)(2), inserted in provision preceding cl. (i) ''items and'' after ''to other''.

Pub. L. 98–369, §2303(b)(1), inserted ''or (D)'' after ''subparagraph (C)''.

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

Subsec. (a)(2)(D). Pub. L. 98–369, §2303(b)(2)–(4), added subpar. (D).

Subsec. (a)(3). Pub. L. 98–369, §2323(b)(1), substituted ''section 1395x(s)(10)(A) of this title'' for ''section 1395x(s)(10) of this title''.

Subsec. (a)(5). Pub. L. 98–369, §2305(b), struck out par. (5) which related to payment of reasonable costs for preadmission diagnostic services described in section 1395x(s)(2)(C) of this title furnished to an individual by the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or to another hospital.

Subsec. (b)(1). Pub. L. 98–369, §2323(b)(2), substituted ''section 1395x(s)(10)(A) of this title'' for ''section 1395x(s)(10) of this title''.

Subsec. (b)(3). Pub. L. 98–369, §2305(d), substituted ''subsection (a)(1)(F)'' for ''subsection (a)(1)(G)''.

Subsec. (b)(4). Pub. L. 98–369, §2303(c), added par. (4).

Subsec. (f). Pub. L. 98–369, §2321(d)(4)(A), transferred subsec. (f) to part C of this subchapter and redesignated its provisions as section 1889 of the Social Security Act, which is classified to section 1395zz of this title.

Subsec. (h). Pub. L. 98–369, §2303(d), amended subsec. (h) generally, substituting provisions directing the Secretary to establish fee schedules for clinical diagnostic laboratory tests at a percentage of the prevailing charge level and nominal fees to cover costs in collecting samples and authorizing the Secretary to make adjustments in the fee schedule, setting forth the recipients of payments, and authorizing the Secretary to establish a negotiated payment rate for provision authorizing the Secretary to establish a negotiated rate of payment with the laboratory which would be considered the full charge for such tests.

Subsec. (h)(5)(C). Pub. L. 98–617, §3(b)(3), inserted a comma before ''under the procedure described in section''.

Subsec. (i)(3). Pub. L. 98–369, §2305(d), substituted ''subsection (a)(1)(F)'' for ''subsection (a)(1)(G)''.

Subsec. (k). Pub. L. 98–369, §2323(b)(4), added subsec. (k).

1982—Subsec. (a)(1)(B). Pub. L. 97–248, §112(a)(1), substituted provisions that with respect to items and servics described in section 1395x(s)(10) of this title, amounts paid shall be 100 percent of reasonable charges for such items and services for provision that with respect to expenses incurred for radiological or pathological services for which payment could be made under this part, furnished to any inpatient of a hospital by a physician in field of radiology or pathology who had in effect an agreement with Secretary by which the physician agreed to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid would be equal to 100 percent of the reasonable charges for such services.

Subsec. (a)(1)(H). Pub. L. 97–248, §112(a)(2), (3), struck out subpar. (H) which provided that, with respect to items and services described in section 1395x(s)(10) of this title, the amount of benefits paid would be 100 percent of reasonable charges for such items and services.

Subsec. (a)(2)(B). Pub. L. 97–248, §101(c)(2), inserted ''and except as may be provided in section 1395ww of this title''.

Subsec. (b)(1). Pub. L. 97–248, §112(b), struck out subpar. (A) provision that total amount of expenses shall not include expenses incurred for radiological or pathological services furnished an individual as an inpatient of a hospital by a physician in field of radiology or pathology who has an agreement with Secretary by which physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients under this part, and redesignated subpar. (B) provisions as par. (1).

Subsec. (i)(1). Pub. L. 97–248, §148(d), struck out requirement of consultation with National Professional Standards Review Council.

Subsec. (j). Pub. L. 97–248, §117(a)(2), added subsec. (j).

1981—Subsec. (a)(2)(A). Pub. L. 97–35, §2106(a), substituted provisions that with respect to home health services and to items and services described in section 1395x(s)(10) of this title, the lesser of reasonable cost of such services as determined under section 1395x(v) of this title or customary charges with respect to such services, or if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title for provisions that with respect to home health services and to items and services described in section 1395x(s)(10) of this title, the reasonable cost of such services, as determined under section 1395x(v) of this title.

Subsec. (a)(2)(B). Pub. L. 97–35, §2106(a), substituted new formula in cls. (i) to (iii) with respect to other services for provisions providing for reasonable costs of such services less the amount a provider may charge as described in section 1395cc(a)(2)(A) of this title and that in no case may payment for such other services exceed 80 percent of such costs.

Subsec. (b). Pub. L. 97–35, §§2133(a), 2134(a), redesignated pars. (2) to (4) as (1) to (3), and struck out former par. (1), which provided that amount of deductible for such calendar year as so determined shall first be reduced by amount of any expenses incurred by such individual in last three months of preceding calendar year and applied toward such individual's deductible under this section for such preceding year.

Pub. L. 97–35, §2134(a), substituted ''by a deductible of $75'' for ''by a deductible of $60''.

1980—Subsec. (a)(1)(B). Pub. L. 96–499, §943(a), inserted ''who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part'' after ''radiology or pathology''.

Subsec. (a)(1)(D). Pub. L. 96–499, §918(a)(4), substituted ''subsection (h)'' for ''subsection (g)''.

Subsec. (a)(1)(F). Pub. L. 96–499, §932(a)(1)(B), added subpar. (F).

Subsec. (a)(1)(G). Pub. L. 96–499, §934(d)(1), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 96–611, §1(b)(1)(A), (B), added subpar. (H).

Subsec. (a)(2). Pub. L. 96–611, §1(b)(1)(C), inserted in subpar. (A) ''and to items and services described in section 1395x(s)(10) of this title''.

Pub. L. 96–499, §942, authorized payment of reasonable cost of home health services and prescribed formulae for determining payment amounts for services other than home health services.

Subsec. (a)(3). Pub. L. 96–611, §1(b)(1)(D), inserted ''(other than for items and services described in section 1395x(s)(10) of this title)''.

Pub. L. 96–499, §942, prescribed a formula for determining payment amounts for services described in subpars. (D) and (E) of section 1395k(a)(2) of this title.

Subsec. (a)(4), (5). Pub. L. 96–499, §942, added pars. (4) and (5).

Subsec. (b)(2). Pub. L. 96–611, §1(b)(2), inserted ''(A)'' after ''expenses incurred'' and added subpar. (B).

Pub. L. 96–499, §943(a), inserted ''who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part''.

Subsec. (b)(3). Pub. L. 96–499, §930(h)(2), added par. (3).

Subsec. (b)(4). Pub. L. 96–499, §934(d)(3), added par. (4).

Subsec. (g). Pub. L. 96–499, §935(a), substituted ''$500'' for ''$100''.

Subsec. (h). Pub. L. 96–473 redesignated subsec. (g) as added by section 279(b) of Pub. L. 92–603 as (h), which for purposes of codification had been editorially set out as subsec. (h), thereby requiring no change in text. See 1972 Amendment note below.

Subsec. (i). Pub. L. 96–499, §934(b), added subsec. (i).

1978—Subsec. (a)(1)(E). Pub. L. 95–292, §4(b)(2), added subpar. (E).

Subsec. (a)(2). Pub. L. 95–292, §4(c), inserted ''(unless otherwise specified in section 1395rr of this title)'' after ''and with respect to other services'' in provisions preceding subpar. (A).

1977—Subsec. (a)(2). Pub. L. 95–210, §1(b)(2), inserted parenthetical provisions preceding subpar. (A) excepting those services described in subpar. (D) of section 1395k(a)(2) of this title.

Subsec. (a)(3). Pub. L. 95–210, §1(b)(1), (3), (4), added par. (3).

Subsec. (f)(1). Pub. L. 95–142 substituted provisions relating to determinations by Secretary with respect to presumptions regarding purchase price or practicality of buying or renting durable medical equipment, for provisions relating to purchase price of durable medical equipment authorized to be paid by Secretary.

Subsec. (f)(2). Pub. L. 95–142 substituted provisions relating to waiver of coinsurance amount in purchase of used durable medical equipment, for provisions relating to reimbursement procedures established by Secretary in cases of rental of durable medical equipment.

Subsec. (f)(3), (4). Pub. L. 95–142 added pars. (3) and (4).

1972—Subsec. (a). Pub. L. 92–603, §226(c)(2), inserted reference to section 1395mm of this title in provisions preceding par. (1).

Subsec. (a)(1). Pub. L. 92–603, §§211(c)(4), 279(a), added subpars. (C) and (D).

Subsec. (a)(2). Pub. L. 92–603, §§233(b), 251(a)(3), 299K(a), substituted subpars. (A) and (B) for provisions relating to the amount payable by reference to section 1395x(v) of this title, added subpar. (C), and in provisions preceding subpar. (A), inserted ''with respect to home health services, 100 percent, and with respect to other services,'' before ''80 percent''.

Subsec. (b). Pub. L. 92–603, §204(a), substituted ''$60'' for ''$50''.

Subsec. (f). Pub. L. 92–603, §245(d), designated existing provisions as par. (1)(A) and added par. (1)(B) and (2).

Subsec. (g). Pub. L. 92–603, §251(a)(2), added subsec. (g).

Subsec. (h). Pub. L. 92–603, §279(b), added subsec. (h). Subsec. was in the original (g) and was changed to accommodate subsec. (g) as added by section 251(a)(2) of Pub. L. 92–603.

1968—Subsec. (a)(1). Pub. L. 90–248, §131(a)(1), (2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b). Pub. L. 90–248, §§129(c)(7), 131(b), struck out reference in par. (1) to expenses regarded under former par. (2) as incurred for services furnished in last three months of preceding year, struck out former par. (2) which provided that amount of any deduction imposed by section 1395e(a)(2)(A) of this title for outpatient hospital diagnostic services furnished in any calendar year is to be regarded as an incurred expense for such year; and added par. (2).

Pub. L. 90–248, §135(c), inserted last sentence providing that there shall be a deductible equal to expenses incurred for first three pints of whole blood (or equivalent quantities of packed red blood cells as defined under regulations) furnished to an individual during a calendar year which deductible is to be appropriately reduced to extent that such blood has been replaced, and such blood will be deemed to have been replaced when institution or person furnishing such blood is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished individual to which three pint deductible applies.

Subsec. (d). Pub. L. 90–248, §129(c)(8), struck out reference to subsection (a)(2)(A) of section 1395e of this title.

Subsec. (f). Pub. L. 90–248, §132(b), added subsec. (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–7, §2(a)(2), Apr. 14, 2021, 135 Stat. 252, provided that: ''The amendments made by this subsection

[amending this section] shall take effect as if included in the enactment of the Consolidated Appropriations Act, 2021 (Public Law 116–260).''

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §114(c), Dec. 27, 2020, 134 Stat. 2948, provided that: ''The amendments made by this section [amending this section and section 1395w–4 of this title] shall take effect on the date of the enactment of this Act [Dec. 27, 2020].''

Pub. L. 116–260, div. CC, title I, §125(g), Dec. 27, 2020, 134 Stat. 2966, provided that: ''The amendments made by this section [amending this section and sections 1395m, 1395x, 1395aa, 1395cc, and 1395dd of this title] shall apply to items and services furnished on or after January 1, 2023.''

Pub. L. 116–136, div. A, title III, §3713(d), Mar. 27, 2020, 134 Stat. 424, provided that: ''The amendments made by this section [amending this section and sections 1395w–22 and 1395x of this title] shall take effect on the date of enactment of this Act [Mar. 27, 2020] and shall apply with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).''

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5012(d), Dec. 13, 2016, 130 Stat. 1202, as amended by Pub. L. 115–123, div. E, title IV, §50401(b)(2), Feb. 9, 2018, 132 Stat. 217, provided that: ''The amendments made by this section [amending this section and sections 1395m, 1395u, and 1395x of this title] shall apply to items and services furnished on or after January 1, 2021, except that the amendments made by paragraphs (1) and (2) of subsection (c) shall apply to items and services furnished on or after January 1, 2019.''

Pub. L. 114–255, div. C, title XVI, §16001(b), Dec. 13, 2016, 130 Stat. 1325, provided that: ''The amendments made by this section [amending this section] shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).''

Pub. L. 114–255, div. C, title XVI, §16002(c), Dec. 13, 2016, 130 Stat. 1326, provided that: ''The amendments made by this section [amending this section] shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).''

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title V, §504(d), Dec. 18, 2015, 129 Stat. 3023, provided that: ''The amendments made by this section [amending this section and sections 1395m and 1395x of this title] shall apply to items furnished on or after January 1, 2017.''

Pub. L. 114–10, title II, §202(b)(2), Apr. 16, 2015, 129 Stat. 144, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to requests described in section 1833(g)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395*l*(g)(5)(C)(i)) with respect to which the Secretary of Health and Human Services has not conducted medical review under such section by a date (not later than 90 days after the date of the enactment of this Act [Apr. 16, 2015]) specified by the Secretary.''

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–96, title III, §3005(e), Feb. 22, 2012, 126 Stat. 189, provided that: ''The requirement of subparagraph (B) of section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395*l*(g)(5)), as added by subsection (a), shall apply to services furnished on or after March 1, 2012.''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title IV, §4103(e), Mar. 23, 2010, 124 Stat. 557, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to services furnished on or after January 1, 2011.''

Pub. L. 111–148, title IV, §4104(d), Mar. 23, 2010, 124 Stat. 558, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2011.''

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §101(c), July 15, 2008, 122 Stat. 2498, provided that: ''The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2009.''

Amendment by section 143(b)(2), (3), of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Pub. L. 110–275, title I, §145(a)(3), July 15, 2008, 122 Stat. 2547, provided that: ''The amendments made by this subsection [amending this section and section 1395w–3 of this title] shall take effect on the date of the enactment of this Act [July 15, 2008].''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §109(c), Dec. 20, 2006, 120 Stat. 2985, provided that: ''The amendments made by this section [amending this section and section 1395ww of this title] shall apply to payment for services furnished on or after January 1, 2009.''

Pub. L. 109–171, title V, §5112(f), Feb. 8, 2006, 120 Stat. 44, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to services furnished on or after January 1, 2007.''

Pub. L. 109–171, title V, §5113(c), Feb. 8, 2006, 120 Stat. 44, provided that: ''The amendments made by this section [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 2007.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 237(a) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

Pub. L. 108–173, title IV, §411(a)(2), Dec. 8, 2003, 117 Stat. 2274, provided that: ''The amendment made by paragraph (1)(B) [amending this section] shall apply with respect to cost reporting periods beginning on and after January 1, 2004.''

Pub. L. 108–173, title IV, §413(b)(2), Dec. 8, 2003, 117 Stat. 2277, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to physicians' services furnished on or after January 1, 2005.''

Pub. L. 108–173, title VI, §614(c), Dec. 8, 2003, 117 Stat. 2306, provided that: ''The amendments made by this section [amending this section] shall apply—

''(1) in the case of screening mammography, to services furnished on or after the date of the enactment of this Act [Dec. 8, 2003]; and

''(2) in the case of diagnostic mammography, to services furnished on or after January 1, 2005.''

Pub. L. 108–173, title VI, §621(a)(6), Dec. 8, 2003, 117 Stat. 2310, provided that: ''The amendments made by this subsection [amending this section] shall apply to items and services furnished on or after January 1, 2004.''

Pub. L. 108–173, title VI, §627(c), Dec. 8, 2003, 117 Stat. 2321, provided that: ''The amendments made by this section [amending this section and sections 1395m and 1395u of this title] shall apply to items furnished on or after January 1, 2005.''

Pub. L. 108–173, title VI, §642(c), Dec. 8, 2003, 117 Stat. 2322, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to items furnished administered [sic] on or after January 1, 2004.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §105(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, provided that: ''The amend-

ments made by this section [amending this section and sections 1395u and 1395x of this title] shall apply to services furnished on or after January 1, 2002.''

Pub. L. 106–554, §1(a)(6) [title I, §111(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to services furnished on or after April 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title II, §201(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: ''The amendment made—

''(1) by subsection (a) [amending section 1395m of this title] shall apply to services furnished on or after the date of the enactment of BBRA [Pub. L. 106–113, §1000(a)(6), approved Nov. 29, 1999];

''(2) by subsection (b)(1) [amending this section] shall apply as if included in the enactment of section 403(e)(1) of BBRA (113 Stat. 1501A–371) [Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)]]; and

''(3) by subsection (b)(2) [amending provisions set out as a note under section 1395m of this title] shall apply as if included in the enactment of section 403(d)(2) of BBRA (113 Stat. 1501A–371) [Pub. L. 106–113, §1000(a)(6) [title IV, §403(d)(2)], set out as a note under section 1395m of this title].''

Pub. L. 106–554, §1(a)(6) [title II, §205(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–483, provided that: ''The amendments made by this section [amending this section and section 1395m of this title] shall apply to services furnished on or after the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, §1(a)(6) [title II, §223(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that: ''The amendments made by subsections (b) and (c) [amending this section and section 1395m of this title] shall be effective for services furnished on or after October 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title II, §224(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–503, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of BBA [Pub. L. 105–33].''

Pub. L. 106–554, §1(a)(6) [title IV, §402(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–505, provided that: ''The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, §1(a)(6) [title IV, §403(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–506, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of BBRA [Pub. L. 106–113, §1000(a)(6)].''

Pub. L. 106–554, §1(a)(6) [title IV, §405(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–507, provided that: ''The amendments made by subsection (a) [amending this section] shall apply as if included in the enactment of section 202 of BBRA [Pub. L. 106–113, §1000(a)(6) [title II, §202]] (113 Stat. 1501A–342).''

Pub. L. 106–554, §1(a)(6) [title IV, §406(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–508, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to devices furnished on or after April 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title IV, §430(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] apply to items and services furnished on or after July 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(h)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–340, provided that: ''The Secretary of Health and Human Services shall first conduct the annual review under the amendment made by paragraph (1)(A) [amending this section] in 2001 for application in 2002 and the amendment made by paragraph (1)(B) [amending this section] takes effect on the date of the enactment of this Act [Nov. 29, 1999].''

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(m)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, provided that: ''Except as provided in this section, the amendments made by this section [amending this section and sections 1395m and 1395x of this title] shall be effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].''

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §202(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–344, provided that: ''The amendments made by this section [amending this section] shall be effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].''

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §204(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–345, provided that: ''The amendments made by this section [amending this section] apply as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33] and shall only apply to procedures performed for which payment is made on the basis of the prospective payment system under section 1833(t) of the Social Security Act [42 U.S.C. 1395*l*(t)].''

Amendment by section 1000(a)(6) [title III, §321(g)(2), (k)(2)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title IV, §401(b)(1)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, §401(c)] of Pub. L. 106–113, set out as a note under section 1395i–4 of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(e)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 29, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4002(j)(1)(B), Aug. 5, 1997, 111 Stat. 330, provided that: ''The amendment made by subparagraph (A) [amending this section] applies to new contracts entered into after the date of enactment of this Act [Aug. 5, 1997] and, with respect to contracts in effect as of such date, shall apply to payment for services furnished after December 31, 1998.''

Pub. L. 105–33, title IV, §4101(d), Aug. 5, 1997, 111 Stat. 360, provided that: ''The amendments made by this section [amending this section and section 1395m of this title] shall apply to items and services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4102(e), Aug. 5, 1997, 111 Stat. 361, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4103(e), Aug. 5, 1997, 111 Stat. 362, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 2000.''

Pub. L. 105–33, title IV, §4104(e), Aug. 5, 1997, 111 Stat. 366, provided that: ''The amendments made by this section [amending this section and sections 1395m, 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 1998.''

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

Pub. L. 105–33, title IV, §4205(a)(1)(B), Aug. 5, 1997, 111 Stat. 376, provided that: ''The amendment made by subparagraph (A) [amending this section] applies to services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4315(c), Aug. 5, 1997, 111 Stat. 390, provided that: ''The amendments made by this sec-

tion [amending this section and section 1395u of this title] to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.''

Amendment by section 4432(b)(5)(C) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(b) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Pub. L. 105–33, title IV, § 4512(d), Aug. 5, 1997, 111 Stat. 444, provided that: ''The amendments made by this section [amending this section and sections 1395u and 1395x of this title] shall apply with respect to services furnished and supplies provided on and after January 1, 1998.''

Pub. L. 105–33, title IV, § 4521(c), Aug. 5, 1997, 111 Stat. 444, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.''

Pub. L. 105–33, title IV, § 4523(d)(1)(A)(ii), Aug. 5, 1997, 111 Stat. 449, provided that: ''The amendment made by clause (i) [amending this section] shall apply to services furnished on or after January 1, 1999.''

Pub. L. 105–33, title IV, § 4531(b)(3), Aug. 5, 1997, 111 Stat. 452, provided that: ''The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 2000.''

Pub. L. 105–33, title IV, § 4541(e), Aug. 5, 1997, 111 Stat. 457, provided that:

''(1) The amendments made by subsections (a)(1), (a)(2), and (b) [amending this section and sections 1395m and 1395y of this title] apply to services furnished on or after January 1, 1998, including portions of cost reporting periods occurring on or after such date, except that section 1834(k) of the Social Security Act [42 U.S.C. 1395m(k)] (as added by subsection (a)(2)) shall not apply to services described in section 1833(a)(8)(B) of such Act [42 U.S.C. 1395*l*(a)(8)(B)] (as added by subsection (a)(1)) that are furnished during 1998.

''(2) The amendments made by subsections (a)(3) and (c) [amending this section and section 1395cc of this title] apply to services furnished on or after January 1, 1999.

''(3) The amendments made by subsection (d)(1) [amending this section] apply to expenses incurred on or after January 1, 1999.''

Pub. L. 105–33, title IV, § 4556(d), Aug. 5, 1997, 111 Stat. 463, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1395u of this title] shall apply to drugs and biologicals furnished on or after January 1, 1998.''

Amendment by section 4603(c)(2)(A) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 123(f)(1), (2), Oct. 31, 1994, 108 Stat. 4412, provided that:

''(1) ENFORCEMENT; MISCELLANEOUS AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a) and (e) [amending this section and section 1395w–4 of this title] shall apply to services furnished on or after the date of the enactment of this Act [Oct. 31, 1994]; except that the amendments made by subsection (a) [amending section 1395w–4 of this title] shall not apply to services of a nonparticipating supplier or other person furnished before January 1, 1995.

''(2) PRACTITIONERS.—The amendments made by subsection (b) [amending this section and section 1395u of this title] shall apply to services furnished on or after January 1, 1995.''

Pub. L. 103–432, title I, § 141(c)(2), Oct. 31, 1994, 108 Stat. 4425, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

Amendment by section 147(a), (e)(2), (3), (f)(6)(C), (D) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, § 147(d)(1), (2), Oct. 31, 1994, 108 Stat. 4429, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Amendment by section 156(a)(2)(B) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13532(b), Aug. 10, 1993, 107 Stat. 587, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to portions of cost reporting periods beginning on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13544(b)(3), Aug. 10, 1993, 107 Stat. 590, provided that: ''The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to items furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13555(b), Aug. 10, 1993, 107 Stat. 592, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4104(d), Nov. 5, 1990, 104 Stat. 1388–59, provided that: ''The amendments made by this section [amending this section and sections 1395m and 1395w–4 of this title] shall apply to services furnished on or after January 1, 1991.''

Amendment by section 4153(a)(2)(B), (C) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(a)(3) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, § 4154(b)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to tests furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4154(c)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: ''The amendment made by paragraph (1)(A) [amending this section] shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272], and the amendment made by paragraph (1)(B) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Pub. L. 101–508, title IV, § 4154(e)(5), Nov. 5, 1990, 104 Stat. 1388–86, as amended by Pub. L. 103–432, title I, § 147(f)(2), Oct. 31, 1994, 108 Stat. 4431, provided that: ''The amendments made by paragraphs (1)(A), (1)(B), (2), and (4) [amending this section, section 1395w–2 of this title, and provisions set out as a note below] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239], and the amendment made by paragraph (1)(C) [amending this section] shall take effect January 1, 1991.''

Amendment by section 4155(b)(2), (3) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(3)(B) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, § 4163(e), Nov. 5, 1990, 104 Stat. 1388–100, as amended by Pub. L. 103–432, title I, § 147(f)(5)(B), Oct. 31, 1994, 108 Stat. 4431, provided that:

''Except as provided in subsection (d)(3) [enacting provisions set out as a note under section 1395y of this title], the amendments made by this section [amending this section and sections 1395m, 1395x, 1395y, 1395z, 1395aa, and 1395bb of this title] shall apply to screening mammography performed on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4206(e)(2), Nov. 5, 1990, 104 Stat. 1388–117, provided that: ''The amendments made by subsection (b) [amending this section and section 1395mm of this title] shall apply to contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] and payments under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395*l*(a)(1)(A)] as of first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6102(c)(2), Dec. 19, 1989, 103 Stat. 2185, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after January 1, 1991.''

Pub. L. 101–239, title VI, §6102(f)(3), Dec. 19, 1989, 103 Stat. 2189, provided that: ''The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 1991.''

Pub. L. 101–239, title VI, §6102(g), Dec. 19, 1989, 103 Stat. 2189, provided that: ''Except as otherwise provided in this section, this section, and the amendments made by this section [enacting section 1395w–4 of this title, amending this section and sections 1395m, 1395u, and 1395rr of this title, and enacting provisions set out as notes under this section and sections 1395m, 1395u, and 1395w–4 of this title], shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

Pub. L. 101–239, title VI, §6111(b)(2), Dec. 19, 1989, 103 Stat. 2214, as amended by Pub. L. 101–508, title IV, §4154(e)(4), Nov. 5, 1990, 104 Stat. 1388–86, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to clinical diagnostic laboratory tests performed on or after May 1, 1990.''

Pub. L. 101–239, title VI, §6113(e), Dec. 19, 1989, 103 Stat. 2217, provided that: ''The amendments made by this section [amending this section and section 1395x of this title], and the provisions of subsection (c) [set out below], shall apply to services furnished on or after July 1, 1990, and the amendments made by subsection (d) [amending this section] shall apply to expenses incurred in a year beginning with 1990.''

Pub. L. 101–239, title VI, §6131(c), Dec. 19, 1989, 103 Stat. 2221, provided that:

''(1) The amendments made by this section [amending this section and section 1395x of this title] shall apply with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

''(2) In applying the amendments made by this section, the increase under subparagraph (C) of section 1833(*o*)(2) of the Social Security Act [42 U.S.C. 1395*l*(*o*)(2)(C)] shall apply to the dollar amounts specified under subparagraph (A) of such section (as amended by this section) in the same manner as the increase would have applied to the dollar amounts specified under subparagraph (A) of such section (as in effect before the date of the enactment of this Act [Dec. 19, 1989]).''

Pub. L. 101–239, title VI, §6133(b), Dec. 19, 1989, 103 Stat. 2222, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1990.''

Amendment by section 6204(b) of Pub. L. 101–239 effective with respect to referrals made on or after Jan. 1, 1992, see section 6204(c) of Pub. L. 101–239, set out as a note under section 1395nn of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Amendment by section 202(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8422(b), Nov. 10, 1988, 102 Stat. 3802, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective as if included in the amendment made by section 9320(e)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(b)(1)–(3) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(c)(1)(A)–(E) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(d)(1) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(c) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(2)(D), (8)(B)(i), (C), (12)(A), (14), (g)(1)(E), (2)(D), (E), (3)(A)–(F), (4)(C), (5), (h)(1)(A), (3)(B), (4)(B), (C), (7)(C), (D), (F), (i)(3), (4)(B)–(C)(ii), (iv), and (vi) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4043(c), Dec. 22, 1987, 101 Stat. 1330–86, provided that: ''The amendments made by this [sic] subsection (a) [amending this section] shall apply with respect to services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) on or after January 1, 1989, and to other services furnished on or after January 1, 1991.''

Amendment by section 4045(c)(2)(A) of Pub. L. 100–203 applicable to items and services furnished on or after Apr. 1, 1988, see section 4045(d) of Pub. L. 100–203, set out as a note under section 1395u of this title.

Amendment by section 4049(a)(1) of Pub. L. 100–203 applicable to services performed on or after Apr. 1, 1989, see section 4049(b)(2) of Pub. L. 100–203, as amended, set out as a note under section 1395m of this title.

Pub. L. 100–203, title IV, §4055(b), formerly §4054(b), as added and renumbered by Pub. L. 100–360, title IV, §411(f)(12)(A), (14), July 1, 1988, 102 Stat. 781, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988.''

Amendment by section 4062(d)(3) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4063(c), Dec. 22, 1987, 101 Stat. 1330–110, provided that: ''The amendments made by this section [amending this section and section 1395u of this title] shall apply to items furnished on or after July 1, 1988.''

Pub. L. 100–203, title IV, §4064(b)(3), Dec. 22, 1987, 101 Stat. 1330–110, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to services furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, § 4064(c)(2), as added by Pub. L. 100–360, title IV, § 411(g)(3)(F), July 1, 1988, 102 Stat. 784, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, § 4066(c), Dec. 22, 1987, 101 Stat. 1330–113, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to outpatient hospital radiology services furnished on or after October 1, 1988, and other diagnostic procedures performed on or after October 1, 1989.''

Pub. L. 100–203, title IV, § 4067(c), Dec. 22, 1987, 101 Stat. 1330–113, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, § 4068(c), Dec. 22, 1987, 101 Stat. 1330–114, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective as if included in the amendment made by section 9343(a)(1)(B) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Pub. L. 100–203, title IV, § 4070(c)(1), Dec. 22, 1987, 101 Stat. 1330–115, provided that: ''The amendment made by subsection (a)(1) [amending this section] shall apply with respect to calendar years beginning with 1988; except that with respect to 1988, any reference in section 1833(c) of the Social Security Act [42 U.S.C. 1395*l*(c)], as amended by subsection (a), to '$1375.00' is deemed a reference to '$562.50'. The amendment made by subsection (a)(2) [amending this section] shall apply to services furnished on or after January 1, 1989.''

For effective date of amendment by section 4072(b) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by section 4073(b) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Amendment by section 4077(b)(2), (3) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4077(b)(5) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Pub. L. 100–203, title IV, § 4084(b), Dec. 22, 1987, 101 Stat. 1330–129, provided that: ''The amendments made by subsection (a) [amending this section] shall apply as if included in the amendment made by section 9320(e)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Pub. L. 100–203, title IV, § 4084(c)(3), as added by Pub. L. 100–360, title IV, § 411(i)(3), July 1, 1988, 102 Stat. 788, provided that: ''The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to services furnished after December 31, 1988.''

Pub. L. 100–203, title IV, § 4085(b)(2), Dec. 22, 1987, 101 Stat. 1330–130, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to procedures performed on or after January 1, 1988.''

Pub. L. 100–203, title IV, § 4085(i)(21), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment to section 9343 of Pub. L. 99–509 by section 4085(i)(21)(D) of Pub. L. 100–203, amending this section and provisions set out as an Effective Date of 1986 Amendments note below, is effective as if included in the enactment of Pub. L. 99–509.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9320(e)(1), (2) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Amendment by section 9337(b) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Pub. L. 99–509, title IX, § 9339(a)(2), Oct. 21, 1986, 100 Stat. 2036, provided that: ''The amendments made by this subsection [amending this section] apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.''

Pub. L. 99–509, title IX, § 9339(c)(2), Oct. 21, 1986, 100 Stat. 2037, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to samples collected on or after January 1, 1987.''

Pub. L. 99–509, title IX, § 9343(h), Oct. 21, 1986, 100 Stat. 2042, as amended by Pub. L. 100–203, title IV, § 4085(i)(21)(D)(ii), (iii), Dec. 22, 1987, 101 Stat. 1330–134; Pub. L. 100–360, title IV, § 411(i)(4)(C)(v), July 1, 1988, 102 Stat. 789, provided that:

''(1) The amendments made by subsection (a)(1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987.

''(2) The amendments made by subsections (b)(1) and (c) [amending this section and sections 1395y and 1395cc of this title] shall apply to services furnished after June 30, 1987.

''(3) The Secretary of Health and Human Services shall first provide, under the amendment made by subsection (b)(2) [amending this section], for the review and update of procedure lists within 6 months after the date of the enactment of this Act [Oct. 21, 1986].

''(4) The amendments made by subsection (d) [amending section 1320c–3 of this title] shall apply to contracts entered into or renewed after January 1, 1987.''

Pub. L. 99–272, title IX, § 9303(a)(2), Apr. 7, 1986, 100 Stat. 188, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to clinical laboratory diagnostic tests performed on or after July 1, 1986.''

Pub. L. 99–272, title IX, § 9303(b)(5)(A), (B), Apr. 7, 1986, 100 Stat. 189, provided that:

''(A) The amendments made by paragraphs (1) and (2) [amending this section] shall apply to clinical diagnostic laboratory tests performed on or after July 1, 1986.

''(B) The amendment made by paragraph (3) [amending this section] shall apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, § 2303(j), July 18, 1984, 98 Stat. 1067, provided that:

''(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and sections 1395u, 1395cc, 1396a, and 1396b of this title and enacting provisions set out as notes under this section and section 1395u of this title] shall apply to clinical diagnostic laboratory tests furnished on or after July 1, 1984.

''(2) The amendments made by subsection (g)(2) [amending section 1396b of this title] shall apply to payments for calendar quarters beginning on or after October 1, 1984.

''(3) The amendments made by this section shall not apply to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of the Social Security Amendments of 1983 [section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title]. Payment for such services shall be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at 80 percent (or 100 percent in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(3)(B)(ii)] or under the procedure described in section 1870(f)(1) of such Act [42 U.S.C. 1395gg(f)(1)]) of the reasonable charge for such service. The deductible under section 1833(b) of such Act [42 U.S.C. 1395*l*(b)] shall not apply to such tests if payment is made on the basis of such an assignment or procedure.''

Pub. L. 98–369, div. B, title III, §2305(e), July 18, 1984, 98 Stat. 1070, provided that: ''The amendments made by this section [amending this section and enacting provisions set out below] shall apply to services performed after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2321(b), (d)(4)(A) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2323(d), July 18, 1984, 98 Stat. 1086, provided that: ''The amendments made by this section [amending this section and sections 1395x, 1395cc, and 1395rr of this title and enacting provisions set out below] apply to services furnished on or after September 1, 1984.''

Amendment by section 2354(b)(5), (7) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §112(c), Sept. 3, 1982, 96 Stat. 340, provided that: ''The amendments made by this section [amending this section] shall apply with respect to items and services furnished on or after October 1, 1982.''

Amendment by section 117(a)(2) of Pub. L. 97–248 applicable to final determinations made on or after Sept. 3, 1982, see section 117(b) of Pub. L. 97–248, set out as a note under section 1395g of this title.

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

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2106(c), Aug. 13, 1981, 95 Stat. 792, provided that: ''The amendment made by subsection (a) [amending this section] is effective as of December 5, 1980, and the amendment made by subsection (b)(2) [amending section 1395q(b) of this title], is effective as of April 1, 1981.''

Pub. L. 97–35, title XXI, §2133(b), Aug. 13, 1981, 95 Stat. 797, provided that: ''The amendments made by subsection (a) [amending this section] first apply to the deductible for calendar year 1982 with respect to expenses incurred on or after October 1, 1981.''

Pub. L. 97–35, title XXI, §2134(b), Aug. 13, 1981, 95 Stat. 797, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1982, and shall apply to the deductible for calendar years beginning with 1982.''

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–611, §2, Dec. 28, 1980, 94 Stat. 3567, provided that: ''The amendments made by this Act [probably should be the amendments made by section 1 of this Act, which amended this section and sections 1395x, 1395y, 1395aa, and 1395cc of this title] shall take effect on, and apply to services furnished on or after, July 1, 1981.''

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

Pub. L. 96–499, title IX, §935(b), Dec. 5, 1980, 94 Stat. 2639, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to expenses incurred in calendar years beginning with calendar year 1982.''

Pub. L. 96–499, title IX, §943(b), Dec. 5, 1980, 94 Stat. 2642, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished after the sixth calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980].''

EFFECTIVE DATE OF 1978 AMENDMENT

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

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Pub. L. 95–142, §16(b), Oct. 25, 1977, 91 Stat. 1201, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977.''

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §204(c), Oct. 30, 1972, 86 Stat. 1377, provided that: ''The amendments made by this section [amending this section and section 1395n of this title] shall be effective with respect to calendar years after 1972 (except that, for purposes of applying clause (1) of the first sentence of section 1833(b) of the Social Security Act [42 U.S.C. 1395*l*(b)], such amendments shall be deemed to have taken effect on January 1, 1972).''

Amendment by section 211(c)(4) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 226(c)(2) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 233(b) of Pub. L. 92–603 applicable to services furnished by hospitals, extended care facilities, and home health agencies in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92–603, set out as a note under section 1395f of this title. See, also, Pub. L. 93–233, §16, Dec. 31, 1973, 87 Stat. 967, set out as a note under section 1395f of this title.

Amendment by section 251(a)(2), (3) of Pub. L. 92–603 applicable with respect to services furnished on or after July 1, 1973, see section 251(d)(1) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §299K(b), Oct. 30, 1972, 86 Stat. 1464, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished by home health agencies in accounting periods beginning after December 31, 1972.''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(7), (8) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §131(c), Jan. 2, 1968, 81 Stat. 850, provided that: ''The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968.''

Pub. L. 90–248, title I, §132(c), Jan. 2, 1968, 81 Stat. 850, provided that: ''The amendments made by this section

[amending this section and section 1395x of this title] shall apply only with respect to items purchased after December 31, 1967.''

Amendment by section 135(c) of Pub. L. 90–248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub. L. 90–248, set out as a note under section 1395e of this title.

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §101(a)(4), July 15, 2008, 122 Stat. 2497, provided that: ''Nothing in the provisions of, or amendments made by, this subsection [amending this section and sections 1395x and 1395y of this title] shall be construed to provide coverage under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] of items and services for the treatment of a medical condition that is not otherwise covered under such title.''

CONSTRUCTION REGARDING LIMITING INCREASES IN COST-SHARING

Pub. L. 106–554, §1(a)(6) [title I, §111(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: ''Nothing in this Act [H.R. 5661, as enacted by section 1(a)(6) of Pub. L. 106–554, see Tables for classification] or the Social Security Act [this chapter] shall be construed as preventing a hospital from waiving the amount of any coinsurance for outpatient hospital services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] that may have been increased as a result of the implementation of the prospective payment system under section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)).''

CENTERS FOR MEDICARE & MEDICAID SERVICES PROVIDER OUTREACH AND REPORTING ON COGNITIVE ASSESSMENT AND CARE PLAN SERVICES

Pub. L. 116–260, div. CC, title I, §116, Dec. 27, 2020, 134 Stat. 2949, provided that:

''(a) OUTREACH.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to Medicare payment for cognitive assessment and care plan services furnished to individuals with cognitive impairment such as Alzheimer's disease and related dementias, identified as of January 1, 2018, by HCPCS code 99483, or any successor to such code (in this section referred to as 'cognitive assessment and care plan services'). Such outreach shall include a comprehensive, one-time education initiative to inform such physicians and practitioners of the addition of such services as a covered benefit under the Medicare program, including the requirements for eligibility for such services.

''(b) REPORTS.—

''(1) HHS REPORT ON PROVIDER OUTREACH.—Not later than one year after the date of enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the outreach conducted under subsection (a). Such report shall include a description of the methods used for such outreach.

''(2) GAO REPORT ON UTILIZATION RATES.—Not later than 3 years after such date of enactment, the Comptroller General of the United States shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the number of Medicare beneficiaries who were furnished cognitive assessment and care plan services for which payment was made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall include information on barriers Medicare beneficiaries face to access such services, and recommendations for such legislative and administrative action as the Comptroller General deems appropriate.''

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3713(e), Mar. 27, 2020, 134 Stat. 424, provided that: ''Notwithstanding any other provision of law, the Secretary [probably means Secretary of Health and Human Services] may implement the provisions of, and the amendments made by, this section [amending this section and sections 1395w–22 and 1395x of this title] by program instruction or otherwise.''

CLAIMS MODIFIER

Pub. L. 116–127, div. F, §6002(b), Mar. 18, 2020, 134 Stat. 203, provided that: ''The Secretary of Health and Human Services shall provide for an appropriate modifier (or other identifier) to include on claims to identify, for purposes of subparagraph (DD) of section 1833(a)(1) [probably means section 1833(a)(1)(DD) of the Social Security Act, 42 U.S.C. 1395*l*(a)(1)(DD)], as added by subsection (a), specified COVID–19 testing-related services described in paragraph (1) of section 1833(cc) of the Social Security Act [42 U.S.C. 1395*l*(cc)], as added by subsection (a), for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection.''

IMPLEMENTATION OF PROVISIONS OF PUB. L. 116–127

Pub. L. 116–127, div. F, §6002(c), Mar. 18, 2020, 134 Stat. 203, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, this section [amending this section and enacting provisions set out as a note above] through program instruction or otherwise.''

IMPLEMENTATION OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §107(b), Dec. 20, 2019, 133 Stat. 3102, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Service may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise.''

IMPLEMENTATION OF 2018 AMENDMENT

Pub. L. 115–141, div. S, title XIII, §1301(a)(3), Mar. 23, 2018, 132 Stat. 1150, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by paragraphs (1) and (2) [amending this section] by program instruction or otherwise.''

IMPROVING DOCUMENTATION OF SERVICES

Pub. L. 114–10, title V, §514(b), Apr. 16, 2015, 129 Stat. 173, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association) and representatives of medicare administrative contractors (as defined in section 1874A(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(r)(5) [42 U.S.C. 1395x(r)(5)] in a manner that demonstrates that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

''(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.

''(3) FUNDING.—The Secretary shall use funds made available under paragraph (10) of section 1893(h) of the

Social Security Act (42 U.S.C. 1395ddd(h)), as added by section 505, to carry out this subsection.''

MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT

Pub. L. 112–242, title I, §101, Jan. 10, 2013, 126 Stat. 2374, as amended by Pub. L. 115–63, title III, §302, Sept. 29, 2017, 131 Stat. 1172; Pub. L. 116–260, div. CC, title I, §104, Dec. 27, 2020, 134 Stat. 2943, provided that:

''(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] to evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globin for the treatment of primary immune deficiency diseases.

''(b) DURATION AND SCOPE.—

''(1) DURATION.—Beginning not later than one year after the date of enactment of this Act [Jan. 10, 2013], the Secretary shall conduct the demonstration project for a period of 3 years and, subject to the availability of funds under subsection (g), the period beginning on October 1, 2017, and ending on December 31, 2023.

''(A) if the date of enactment of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 is on or before September 30, 2017 [Pub. L. 115–63 was approved Sept. 29, 2017], for the period beginning on October 1, 2017, and ending on December 31, 2020; and

''(B) if the date of enactment of such Act is after September 30, 2017, for the period beginning on the date of enactment of such Act and ending on December 31, 2020.

''(2) SCOPE.—The Secretary shall enroll for participation in the demonstration project for the period beginning on October 1, 2014, and ending on September 30, 2020, not more than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency disease and for the period beginning on October 1, 2014, and ending on December 31, 2023, not more than 6,500 Medicare beneficiaries who have been so diagnosed. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time. Subject to the preceding sentence, a Medicare beneficiary enrolled in the demonstration project on September 30, 2017, shall be automatically enrolled during the period beginning on the date of the enactment of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 and ending on December 31, 2023, without submission of another application.

''(c) COVERAGE.—Except as otherwise provided in this section, items and services for which payment may be made under the demonstration program shall be treated and covered under part B of title XVIII of the Social Security Act in the same manner as similar items and services covered under such part.

''(d) PAYMENT.—The Secretary shall establish a per visit payment amount for items and services needed for the in-home administration of intravenous immune globin based on the national per visit low-utilization payment amount under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as may be necessary to carry out the demonstration project.

''(f) STUDY AND REPORT TO CONGRESS.—

''(1) INTERIM EVALUATION AND REPORT.—Not later than three years after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains an interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

''(2) UPDATED EVALUATION AND REPORT.—Not later than 2 years after the date of the enactment of [the] Consolidated Appropriations Act, 2021 [Dec. 27, 2020], the Secretary shall submit to Congress an updated report that contains the following:

''(A) The total number of beneficiaries enrolled in the demonstration project during the updated report period.

''(B) The total number of claims submitted for services during the updated report period, disaggregated by month.

''(C) An analysis of the impact of the demonstration on beneficiary access to the in-home administration of intravenous immune globin, including the impact on beneficiary health.

''(D) An analysis of the impact of in-home administration of intravenous immune globin on overall costs to Medicare, including the cost differential between in-home administration of intravenous immune globin and administration of intravenous immune globin in a healthcare facility.

''(E) To the extent practicable, a survey of providers and enrolled beneficiaries that participated in the demonstration project that identifies barriers to accessing services, including reimbursement for items and services.

''(F) Recommendations to Congress on the appropriateness of establishing a permanent bundled services payment for the in-home administration of intravenous immune globin for Medicare beneficiaries.

''(3) FINAL EVALUATION AND REPORT.—Not later than one year after the date of completion of the demonstration project, the Secretary shall submit to Congress a report that contains the following:

''(A) A final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

''(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k [1395j] et seq.).

''(C) An update to the report entitled 'Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)', issued in February 2007 by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

''(g) FUNDING.—There shall be made available to the Secretary to carry out the demonstration project not more than $45,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

''(h) DEFINITIONS.—In this section:

''(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means the demonstration project conducted under this section.

''(2) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is enrolled for benefits under part B of title XVIII of the Social Security Act.

''(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(4) UPDATED REPORT PERIOD.—The term 'updated report period' means the period beginning on October 1, 2014, and ending on September 30, 2020.''

[Pub. L. 116–260, §104(b), (c), which directed amendment of section 101 without specifying the Act to be amended, was executed to section 101 of Pub. L. 112–242, set out above, to reflect the probable intent of Congress.]

IMPLEMENTATION OF 2013 AMENDMENT

Pub. L. 112–240, title VI, §603(d), Jan. 2, 2013, 126 Stat. 2347, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, and the amendments made by, this section [amending this section] by program instruction or otherwise.''

IMPLEMENTATION OF 2012 AMENDMENT

Pub. L. 112–96, title III, § 3005(d), Feb. 22, 2012, 126 Stat. 189, provided that: ''The Secretary of Health and Human Services shall implement such claims processing edits and issue such guidance as may be necessary to implement the amendments made by this section [amending this section and section 1395u of this title] in a timely manner. Notwithstanding any other provision of law, the Secretary may implement the amendments made by this section by program instruction. Of the amount of funds made available to the Secretary for fiscal year 2012 for program management for the Centers for Medicare & Medicaid Services, not to exceed $9,375,000 shall be available for such fiscal year and the first 3 months of fiscal year 2013 to carry out section 1833(g)(5)(C) of the Social Security Act [42 U.S.C. 1395*l*(g)(5)(C)] (relating to manual medical review), as added by subsection (a).''

COLLECTION OF ADDITIONAL DATA

Pub. L. 112–96, title III, § 3005(g), Feb. 22, 2012, 126 Stat. 189, provided that:

''(1) STRATEGY.—The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395*l*(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.

''(2) CONSULTATION.—In proposing and implementing such strategy, the Secretary shall consult with relevant stakeholders.''

TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS

Pub. L. 111–148, title III, § 3113, Mar. 23, 2010, 124 Stat. 422, provided that:

''(a) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a demonstration project under part B [of] title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

''(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term 'complex diagnostic laboratory test' means a diagnostic laboratory test—

''(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

''(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

''(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

''(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

''(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

''(3) SEPARATE PAYMENT DEFINED.—In this section, the term 'separate payment' means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such [sic] Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

''(b) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

''(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

''(1) be made from the Federal Supplemental [probably should be ''Supplementary''] Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

''(2) may not exceed $100,000,000.

''(d) REPORT.—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

''(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (including any savings under such title); and

''(2) such recommendations as the Secretary determines appropriate.

''(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental [probably should be ''Supplementary''] Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.''

TREATMENT OF CERTIFIED REGISTERED NURSE ANESTHETISTS

Pub. L. 110–275, title I, § 139(b), July 15, 2008, 122 Stat. 2541, provided that: ''With respect to items and services furnished on or after January 1, 2010, the Secretary of Health and Human Services shall make appropriate adjustments to payments under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for teaching certified registered nurse anesthetists to implement a policy with respect to teaching certified registered nurse anesthetists that—

''(1) is consistent with the adjustments made by the special rule for teaching anesthesiologists under section 1848(a)(6) of the Social Security Act [42 U.S.C. 1395w–4(a)(6)], as added by subsection (a); and

''(2) maintains the existing payment differences between teaching anesthesiologists and teaching certified registered nurse anesthetists.''

IMPLEMENTATION OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, § 107(b)(2), Dec. 20, 2006, 120 Stat. 2983, provided that: ''The Secretary of Health and Human Services may implement the amendment made by paragraph (1) [amending this section] by program instruction or otherwise.''

Pub. L. 109–171, title V, § 5107(a)(2), Feb. 8, 2006, 120 Stat. 42, provided that: ''The Secretary of Health and Human Services shall waive such provisions of law and regulation (including those described in section 110(c) of Public Law 108–173 [set out as a note under section 1395w–101 of this title]) as are necessary to implement the amendments made by paragraph (1) [amending this section] on a timely basis and, notwithstanding any other provision of law, may implement such amendments by program instruction or otherwise. There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395*oo*), or otherwise of the process (including the establishment of the process) under section

1833(g)(5) of such Act [42 U.S.C. 1395*l*(g)(5)], as added by paragraph (1).''

IMPLEMENTATION OF CLINICALLY APPROPRIATE CODE EDITS IN ORDER TO IDENTIFY AND ELIMINATE IMPROPER PAYMENTS FOR THERAPY SERVICES

Pub. L. 109–171, title V, § 5107(b), Feb. 8, 2006, 120 Stat. 43, provided that: ''By not later than July 1, 2006, the Secretary of Health and Human Services shall implement clinically appropriate code edits with respect to payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physical therapy services, occupational therapy services, and speech-language pathology services in order to identify and eliminate improper payments for such services, including edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY

Pub. L. 108–173, title III, § 305(b), Dec. 8, 2003, 117 Stat. 2255, required the Comptroller General of the United States to conduct a study to examine the adequacy of reimbursements for inhalation therapy under the medicare program, and to submit to Congress a report on this study not later than 1 year after Dec. 8, 2003.

TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS

Pub. L. 108–173, title IV, § 416, Dec. 8, 2003, 117 Stat. 2282, as amended by Pub. L. 109–432, div. B, title I, § 105, Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–173, title I, § 107, Dec. 29, 2007, 121 Stat. 2496; Pub. L. 111–148, title III, § 3122, Mar. 23, 2010, 124 Stat. 423; Pub. L. 111–309, title I, § 109, Dec. 15, 2010, 124 Stat. 3288, provided that:

''(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] that is furnished during a cost reporting period described in subsection (b) by a hospital with fewer than 50 beds that is located in a qualified rural area (identified under paragraph (12)(B)(iii) of section 1834(*l*) of the Social Security Act (42 U.S.C. 1395m(*l*)), as added by section 414(c)) as part of outpatient services of the hospital, the amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

''(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the period beginning on July 1, 2004, and ending on June 30, 2008 or during the 2-year period beginning on July 1, 2010.

''(c) PROVISION AS PART OF OUTPATIENT HOSPITAL SERVICES.—For purposes of subsection (a), in determining whether clinical diagnostic laboratory services are furnished as part of outpatient services of a hospital, the Secretary [of Health and Human Services] shall apply the same rules that are used to determine whether clinical diagnostic laboratory services are furnished as an outpatient critical access hospital service under section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)).''

[Pub. L. 109–432, div. B, title I, § 105, Dec. 20, 2006, 120 Stat. 2981, provided that the amendment made by that section to section 416(b) of Pub. L. 108–173, set out above, is effective as if included in the enactment of section 416 of Pub. L. 108–173.]

GAO REPORT ON PAYMENTS FOR BRACHYTHERAPY DEVICES

Pub. L. 108–173, title VI, § 621(b)(3), Dec. 8, 2003, 117 Stat. 2311, provided that: ''The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(16)(C) of the Social Security Act [42 U.S.C. 1395*l*(t)(16)(C)], as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary [of Health and Human Services] a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.''

MORATORIUM ON PHYSICAL THERAPY SERVICES CAPS IN 2003

Pub. L. 108–173, title VI, § 624(a)(2), Dec. 8, 2003, 117 Stat. 2317, provided that: ''For the period beginning on the date of the enactment of this Act [Dec. 8, 2003] and ending of [sic] December 31, 2003, the Secretary [of Health and Human Services] shall not apply the provisions of paragraphs (1), (2), and (3) of section 1833(g) [42 U.S.C. 1395*l*(g)] to expenses incurred with respect to services described in such paragraphs during such period. Nothing in the preceding sentence shall be construed as affecting the application of such paragraphs by the Secretary before the date of the enactment of this Act.''

PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES

Pub. L. 108–173, title VI, § 624(b), Dec. 8, 2003, 117 Stat. 2317, provided that: ''Not later than March 31, 2004, the Secretary [of Health and Human Services] shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 457) [set out as a note under this section] (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–352), as enacted into law by section 1000(a)(6) of Public Law 106–113 [set out as a note under this section] (relating to utilization patterns for outpatient therapy).''

GAO STUDY OF AMBULATORY SURGICAL CENTER PAYMENTS

Pub. L. 108–173, title VI, § 626(d), Dec. 8, 2003, 117 Stat. 2319, provided that:

''(1) STUDY.—

''(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments under section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)). The study shall also examine how accurately ambulatory payment categories reflect procedures furnished in ambulatory surgical centers.

''(B) CONSIDERATION OF ASC DATA.—In conducting the study under paragraph (1), the Comptroller General shall consider data submitted by ambulatory surgical centers regarding the matters described in clauses (i) through (iii) of paragraph (2)(B).

''(2) REPORT AND RECOMMENDATIONS.—

''(A) REPORT.—Not later than January 1, 2005, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

''(B) RECOMMENDATIONS.—The report submitted under subparagraph (A) shall include recommendations on the following matters:

''(i) The appropriateness of using the groups of covered services and relative weights established under the outpatient prospective payment system as the basis of payment for ambulatory surgical centers.

''(ii) If the relative weights under such hospital outpatient prospective payment system are appropriate for such purpose—

''(I) whether the payment rates for ambulatory surgical centers should be based on a uniform percentage of the payment rates or weights under such outpatient system; or

''(II) whether the payment rates for ambulatory surgical centers should vary, or the weights should be revised, based on specific procedures or types of services (such as ophthalmology and pain management services).

''(iii) Whether a geographic adjustment should be used for payment of services furnished in ambulatory surgical centers, and if so, the labor and nonlabor shares of such payment.''

DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS

Pub. L. 108–173, title VI, §641, Dec. 8, 2003, 117 Stat. 2321, provided that:

''(a) DEMONSTRATION PROJECT.—The Secretary [of Health and Human Services] shall conduct a demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment is made under such part. Such project shall provide for cost-sharing applicable with respect to such drugs or biologicals in the same manner as cost-sharing applies with respect to part D [part D of this subchapter] drugs under standard prescription drug coverage (as defined in section 1860D–2(b) of the Social Security Act [42 U.S.C. 1395w–102(b)], as added by section 101(a)).

''(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in sites selected by the Secretary.

''(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act [Dec. 8, 2003], but in no case may the project extend beyond December 31, 2005.

''(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

''(1) coverage for more than 50,000 patients; and

''(2) more than $500,000,000 in funding.

''(e) REPORT.—Not later than July 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.''

PAYMENT FOR PANCREATIC ISLET CELL INVESTIGATIONAL TRANSPLANTS FOR MEDICARE BENEFICIARIES IN CLINICAL TRIALS

Pub. L. 108–173, title VII, §733, Dec. 8, 2003, 117 Stat. 2352, provided that:

''(a) CLINICAL TRIAL.—

''(1) IN GENERAL.—The Secretary [of Health and Human Services], acting through the National Institute of Diabetes and Digestive and Kidney Disorders, shall conduct a clinical investigation of pancreatic islet cell transplantation which includes medicare beneficiaries.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to conduct the clinical investigation under paragraph (1).

''(b) MEDICARE PAYMENT.—Not earlier than October 1, 2004, the Secretary shall pay for the routine costs as well as transplantation and appropriate related items and services (as described in subsection (c)) in the case of medicare beneficiaries who are participating in a clinical trial described in subsection (a) as if such transplantation were covered under title XVIII of such Act [42 U.S.C. 1395 et seq.] and as would be paid under part A or part B of such title [42 U.S.C. 1395c et seq., 1395j et seq.] for such beneficiary.

''(c) SCOPE OF PAYMENT.—For purposes of subsection (b):

''(1) The term 'routine costs' means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

''(2) The term 'transplantation and appropriate related items and services' means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

''(3) The term 'medicare beneficiary' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.], or both.

''(d) CONSTRUCTION.—The provisions of this section shall not be construed—

''(1) to permit payment for partial pancreatic tissue or islet cell transplantation under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] other than payment as described in subsection (b); or

''(2) as authorizing or requiring coverage or payment conveying—

''(A) benefits under part A of such title [42 U.S.C. 1395c et seq.] to a beneficiary not entitled to such part A; or

''(B) benefits under part B of such title [42 U.S.C. 1395j et seq.] to a beneficiary not enrolled in such part B.''

GAO STUDY OF REDUCTION IN MEDIGAP PREMIUM LEVELS RESULTING FROM REDUCTIONS IN COINSURANCE

Pub. L. 106–554, §1(a)(6) [title I, §111(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, related to GAO study of reduction in medigap premium levels resulting from reductions in coinsurance and subsequent report to Congress, prior to repeal by Pub. L. 114–301, §2(b), Dec. 16, 2016, 130 Stat. 1514.

MEDPAC STUDY ON LOW-VOLUME, ISOLATED RURAL HEALTH CARE PROVIDERS

Pub. L. 106–554, §1(a)(6) [title II, §225], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the effect of low patient and procedure volume on the financial status of low-volume, isolated rural health care providers participating in the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a) indicating—

''(1) whether low-volume, isolated rural health care providers are having, or may have, significantly decreased medicare margins or other financial difficulties resulting from any of the payment methodologies described in subsection (c);

''(2) whether the status as a low-volume, isolated rural health care provider should be designated under the medicare program and any criteria that should be used to qualify for such a status; and

''(3) any changes in the payment methodologies described in subsection (c) that are necessary to provide appropriate reimbursement under the medicare program to low-volume, isolated rural health care providers (as designated pursuant to paragraph (2)).

''(c) PAYMENT METHODOLOGIES DESCRIBED.—The payment methodologies described in this subsection are the following:

''(1) The prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)).

''(2) The fee schedule for ambulance services under section 1834(*l*) of such Act (42 U.S.C. 1395m(*l*)).

''(3) The prospective payment system for inpatient hospital services under section 1886 of such Act (42 U.S.C. 1395ww).

''(4) The prospective payment system for routine service costs of skilled nursing facilities under section 1888(e) of such Act (42 U.S.C. 1395yy(e)).

''(5) The prospective payment system for home health services under section 1895 of such Act (42 U.S.C. 1395fff).''

SPECIAL RULE FOR PAYMENT FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §401(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–503, provided that: ''Notwithstanding the amendment made by subsection (a) [amending this section], for purposes of making payments under section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) for covered OPD services furnished during 2001, the medicare OPD fee schedule amount under such section—

''(1) for services furnished on or after January 1, 2001, and before April 1, 2001, shall be the medicare OPD fee schedule amount for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for services furnished on or after April 1, 2001, and before January 1, 2002, shall be the fee schedule amount (as determined taking into account the amendment made by subsection (a)), increased by a transitional percentage allowance equal to 0.32 percent (to account for the timing of implementation of the full market basket update).''

TRANSITION PROVISIONS APPLICABLE TO SUBSECTION (t)(6)(B)

Pub. L. 106–554, §1(a)(6) [title IV, §402(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–506, provided that:

''(1) IN GENERAL.—In the case of a medical device provided as part of a service (or group of services) furnished during the period before initial categories are implemented under subparagraph (B)(i) of section 1833(t)(6) of the Social Security Act [42 U.S.C. 1395*l*(t)(6)(B)(i)] (as amended by subsection (a)), payment shall be made for such device under such section in accordance with the provisions in effect before the date of the enactment of this Act [Dec. 21, 2000]. In addition, beginning on the date that is 30 days after the date of the enactment of this Act, payment shall be made for such a device that is not included in a program memorandum described in such subparagraph if the Secretary of Health and Human Services determines that the device (including a device that would have been included in such program memoranda but for the requirement of subparagraph (A)(iv)(I) of that section) is likely to be described by such an initial category.

''(2) APPLICATION OF CURRENT PROCESS.—Notwithstanding any other provision of law, the Secretary shall continue to accept applications with respect to medical devices under the process established pursuant to paragraph (6) of section 1833(t) of the Social Security Act [42 U.S.C. 1395*l*(t)(6)] (as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]) through December 1, 2000, and any device—

''(A) with respect to which an application was submitted (pursuant to such process) on or before such date; and

''(B) that meets the requirements of clause (ii) or (iv) of subparagraph (A) of such paragraph (as determined pursuant to such process),

shall be treated as a device with respect to which an initial category is required to be established under subparagraph (B)(i) of such paragraph (as amended by subsection (a)(2)).''

STUDY ON STANDARDS FOR SUPERVISION OF PHYSICAL THERAPIST ASSISTANTS

Pub. L. 106–554, §1(a)(6) [title IV, §421(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, required the Secretary of Health and Human Services to conduct a study of the implications of eliminating the ''in the room'' supervision requirement for medicare payment for services of physical therapy assistants who are supervised by physical therapists and of such requirement on the cap imposed under subsec. (g) of this section on physical therapy services, and to submit to Congress a report on the study no later than 18 months after Dec. 21, 2000.

DELAY IN IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM FOR AMBULATORY SURGICAL CENTERS

Pub. L. 106–554, §1(a)(6) [title IV, §424(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: ''The Secretary of Health and Human Services may not implement a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395*l*(i)) before January 1, 2002.''

MEDPAC STUDY AND REPORT ON MEDICARE REIMBURSEMENT FOR SERVICES PROVIDED BY CERTAIN PROVIDERS

Pub. L. 106–554, §1(a)(6) [title IV, §434], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the current payment rates under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services provided by a—

''(1) certified nurse-midwife (as defined in subsection (gg)(2) of section 1861 of such Act (42 U.S.C. 1395x));

''(2) physician assistant (as defined in subsection (aa)(5)(A) of such section);

''(3) nurse practitioner (as defined in such subsection); and

''(4) clinical nurse specialist (as defined in subsection (aa)(5)(B) of such section).

The study shall separately examine the appropriateness of such payment rates for orthopedic physician assistants, taking into consideration the requirements for accreditation, training, and education.

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

MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN MANAGEMENT SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §438], Dec. 21, 2000, 114 Stat. 2763, 2763A–528, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. Such study shall examine—

''(1) the specific barriers imposed under the medicare program on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physicians' offices; and

''(2) the consistency of medicare payment policies for pain management procedures in those different settings.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study.''

ESTABLISHMENT OF CODING AND PAYMENT PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE

Pub. L. 106–554, §1(a)(6) [title V, §531(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–547, provided that: ''Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall establish procedures for coding and payment determinations for the categories of new clinical diagnostic laboratory tests and new durable medical equipment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] that permit public consultation in a manner consistent with the procedures established for implementing coding modifications for ICD–9–CM.''

REPORT ON PROCEDURES USED FOR ADVANCED, IMPROVED TECHNOLOGIES

Pub. L. 106–554, §1(a)(6) [title V, §531(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–547, provided that: ''Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit to Congress a report that identifies the specific procedures used by the Secretary under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] to adjust payments for clinical diagnostic laboratory tests and durable medical equipment which are classified to existing codes where, because of an advance in technology with respect to the test or equipment, there has been a significant increase or decrease in the resources used in the test or in the manufacture of the equipment, and there has been a significant improvement in the performance of the test or equipment. The report shall include such recommendations for changes in law as may be necessary to assure fair and appropriate payment levels under such part for such improved tests and equipment as reflects increased costs necessary to produce improved results.''

CONGRESSIONAL INTENTION REGARDING BASE AMOUNTS IN APPLYING HOPD PPS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(*l*)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, provided that: ''With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act [42 U.S.C. 1395*l*(t)(3)(A)(ii)], as added by section 4523(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33], Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.''

STUDY AND REPORT TO CONGRESS REGARDING SPECIAL TREATMENT OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §203], Nov. 29, 1999, 113 Stat. 1536, 1501A–344, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Medicare Payment Advisory Commission (referred to in this section as 'MedPAC') shall conduct a study to determine the appropriateness (and the appropriate method) of providing payments to hospitals described in paragraph (2) for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) based on the prospective payment system established by the Secretary in accordance with such section.

''(2) HOSPITALS DESCRIBED.—The hospitals described in this paragraph are the following:

''(A) A medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

''(B) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

''(C) Rural health clinics (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2)).

''(D) Rural referral centers (as so classified under section 1886(d)(5)(C) of such Act (42 U.S.C. 1395ww(d)(5)(C)).

''(E) Any other rural hospital with not more than 100 beds.

''(F) Any other rural hospital that the Secretary determines appropriate.

''(G) A hospital described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

''(c) COMMENTS.—Not later than 60 days after the date on which MedPAC submits the report under subsection (b) to the Secretary of Health and Human Services, the Secretary shall submit comments on such report to Congress.''

GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §213], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services under the medicare program. In making such determination, the Comptroller General shall—

''(1) determine the adequacy of practice expense relative value units associated with the utilization of those clinical resources;

''(2) determine the adequacy of work units in the practice expense formula; and

''(3) assess various standards to assure the provision of safe outpatient cancer therapy services.

''(b) REPORT TO CONGRESS.—The Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding practice expense adjustments to the payment methodology under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study shall also include an estimate of the cost of implementing such recommendations.''

FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, as amended by Pub. L. 106–554, §1(a)(6) [title IV, §421(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, provided that: ''During years in which paragraph (4) of section 1833(g) of the Social Security Act (42 U.S.C. 1395*l*(g)) applies, the Secretary of Health and Human Services shall conduct focused medical reviews of claims for reimbursement for services described in paragraph (1) or (3) of such section, with an emphasis on such claims for services that are provided to residents of skilled nursing facilities.''

STUDY AND REPORT ON UTILIZATION

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that:

''(1) STUDY.—

''(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study which compares—

''(i) utilization patterns (including nationwide patterns, and patterns by region, types of settings, and diagnosis or condition) of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395) [42 U.S.C. 1395 et seq.] and provided on or after January 1, 2000; with

''(ii) such patterns for such services that were provided in 1998 and 1999.

''(B) REVIEW OF CLAIMS.—In conducting the study under this subsection the Secretary of Health and Human Services shall review a statistically significant number of claims for reimbursement for the services described in subparagraph (A).

''(2) REPORT.—Not later than June 30, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.''

PHASE-IN OF PPS FOR AMBULATORY SURGICAL CENTERS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §226], Nov. 29, 1999, 113 Stat. 1536, 1501A–354, as amended by Pub. L. 106–554, §1(a)(6) [title IV, §424(b), (c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, 2763A–519, provided that: ''If the Secretary of Health and Human Services implements a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395*l*(i)), prior to incorporating data from the 1999 Medicare cost survey or a subsequent cost survey, such system shall be implemented in a manner so that—

''(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed one-fourth) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

''(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed one-half and three-fourths, respectively) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.

By not later than January 1, 2003, the Secretary shall incorporate data from a 1999 medicare cost survey or a subsequent cost survey for purposes of implementing or revising such system.''

MEDPAC STUDY ON POSTSURGICAL RECOVERY CARE CENTER SERVICES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §229(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, provided that:

''(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29,1999], the Commission shall submit to Congress a report on such study and shall include in the report recommendations on the feasibility, costs, and savings of covering such services under the medicare program.''

MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES

Pub. L. 105–33, title IV, §4206, Aug. 5, 1997, 111 Stat. 377, as amended by Pub. L. 106–554, §1(a)(6) [title II, §223(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that:

''(a) IN GENERAL.—For services furnished on and after January 1, 1999, and before October 1, 2001, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r)) or a practitioner (described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

''(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

''(1) The payment shall [be] shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.

''(2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.

''(3) The payment shall be made subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*).

''(4) The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

''(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1999, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

''(1) how telemedicine and telehealth systems are expanding access to health care services;

''(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

''(3) the quality of telemedicine and telehealth servics delivered; and

''(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

''(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with such a physician or practitioner furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwith-

standing that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

''(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

''(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs and savings to the medicare program of making the payments described in that paragraph using various reimbursement schemes.''

REPORT ON COVERAGE OF OUTPATIENT OCCUPATIONAL THERAPY SERVICES

Pub. L. 105–33, title IV, §4541(d)(2), Aug. 5, 1997, 111 Stat. 457, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(c)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, provided that: ''Not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on—

''(A) the establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395) [42 U.S.C. 1395 et seq.]; and

''(B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the uniform dollar limitations specified in section 1833(g) of such Act [42 U.S.C. 1395*l*(g)], as amended by paragraph (1).

The recommendations shall include how such a mechanism or policy might be implemented in a budget-neutral manner.''

[Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(c)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that: ''The amendment made by paragraph (1) [amending section 4541(d)(2) of Pub. L. 105–33, set out above] shall take effect as if included in the enactment of section 4541 of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].'']

STUDY AND REPORT ON CLINICAL LABORATORY TESTS

Pub. L. 105–33, title IV, §4553(c), Aug. 5, 1997, 111 Stat. 460, required the Secretary to request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for clinical laboratory tests, including a review of the adequacy of the current methodology and recommendations regarding alternative payment systems analysis and of the relationship between such payment systems and access to high quality laboratory tests for medicare beneficiaries, including availability and access to new testing methodologies, and to report to Congress the results of the study and any recommendations for legislation not later than 2 years after Aug. 5, 1997..''

ADJUSTMENTS TO PAYMENT AMOUNTS FOR NEW TECHNOLOGY INTRAOCULAR LENSES

Pub. L. 103–432, title I, §141(b), Oct. 31, 1994, 108 Stat. 4425, provided that:

''(1) ESTABLISHMENT OF PROCESS FOR REVIEW OF AMOUNTS.—Not later than 1 year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall develop and implement a process under which interested parties may request review by the Secretary of the appropriateness of the reimbursement amount provided under section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395*l*(i)(2)(A)(iii)] with respect to a class of new technology intraocular lenses. For purposes of the preceding sentence, an intraocular lens may not be treated as a new technology lens unless it has been approved by the Food and Drug Administration.

''(2) FACTORS CONSIDERED.—In determining whether to provide an adjustment of payment with respect to a particular lens under paragraph (1), the Secretary shall take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages.

''(3) NOTICE AND COMMENT.—The Secretary shall publish notice in the Federal Register from time to time (but no less often than once each year) of a list of the requests that the Secretary has received for review under this subsection, and shall provide for a 30-day comment period on the lenses that are the subjects of the requests contained in such notice. The Secretary shall publish a notice of the Secretary's determinations with respect to intraocular lenses listed in the notice within 90 days after the close of the comment period.

''(4) EFFECTIVE DATE OF ADJUSTMENT.—Any adjustment of a payment amount (or payment limit) made under this subsection shall become effective not later than 30 days after the date on which the notice with respect to the adjustment is published under paragraph (3).''

STUDY OF MEDICARE COVERAGE OF PATIENT CARE COSTS ASSOCIATED WITH CLINICAL TRIALS OF NEW CANCER THERAPIES

Pub. L. 103–432, title I, §142, Oct. 31, 1994, 108 Stat. 4426, directed Secretary of Health and Human Services to conduct a study, and to submit a report to Congress not later than 2 years after Oct. 31, 1994, of effects of expressly covering under medicare program patient care costs for beneficiaries enrolled in clinical trials of new cancer therapies, where protocol for the trial has been approved by the National Cancer Institute or met similar scientific and ethical standards, including approval by an institutional review board.

STUDY OF ANNUAL CAP ON AMOUNT OF MEDICARE PAYMENT FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES

Pub. L. 103–432, title I, §143, Oct. 31, 1994, 108 Stat. 4426, directed Secretary of Health and Human Services to submit to Congress, not later than Jan. 1, 1996, study and report on appropriateness of continuing annual limitation on amount of payment for outpatient services of independently practicing physical and occupational therapists under medicare program, which was to include such recommendations for changes in such annual limitation as Secretary found appropriate.

AMBULATORY SURGICAL CENTER SERVICES; INFLATION UPDATE

Pub. L. 103–66, title XIII, §13531, Aug. 10, 1993, 107 Stat. 586, provided that: ''The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act [42 U.S.C. 1395*l*(i)(2)(A), (B)] for fiscal year 1994 or for fiscal year 1995.''

FREEZE IN ALLOWANCE FOR INTRAOCULAR LENSES

Pub. L. 103–66, title XIII, §13533, Aug. 10, 1993, 107 Stat. 587, provided that: ''Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395*l*(i)(2)(A)(iii)], the amount of payment determined

under such section for an intraocular lens inserted subsequent to or during cataract surgery in an ambulatory surgical center on or after January 1, 1994, and before January 1, 1999, shall be equal to $150.''

Pub. L. 101–508, title IV, §4151(c)(3), Nov. 5, 1990, 104 Stat. 1388–73, as amended by Pub. L. 103–432, title I, §141(d), Oct. 31, 1994, 108 Stat. 4426, provided that: ''Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395*l*(i)(2)(A)(iii)], the amount of payment determined under such section for an intraocular lens inserted during or subsequent to cataract surgery furnished to an individual in an ambulatory surgical center on or after the date of the enactment of this Act [Nov. 5, 1990] and on or before December 31, 1992, shall be equal to $200.''

[Pub. L. 103–432, title I, §141(d), Oct. 31, 1994, 108 Stat. 4426, provided that the amendment made by that section to section 4151(c)(3) of Pub. L. 101–508, set out above, is effective as if included in the enactment of Pub. L. 101–508.]

REDUCTION IN PAYMENTS UNDER PART B DURING FINAL TWO MONTHS OF 1990

Pub. L. 101–508, title IV, §4158, Nov. 5, 1990, 104 Stat. 1388–89, provided that:

''(a) IN GENERAL.—Notwithstanding any other provision of law (including any other provision of this Act, other than subsection (b)(4)), payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for items and services furnished during the period beginning on November 1, 1990, and ending on December 31, 1990, shall be reduced by 2 percent, in accordance with subsection (b).

''(b) SPECIAL RULES FOR APPLICATION OF REDUCTION.—

''(1) PAYMENT ON THE BASIS OF COST REPORTING PERIODS.—In the case in which payment for services of a provider of services is made under part B of such title on a basis relating to the reasonable cost incurred for the services during a cost reporting period of the provider, the reduction made under subsection (a) shall be applied to payment for costs for such services incurred at any time during each cost reporting period of the provider any part of which occurs during the period described in such subsection, but only in the same proportion as the fraction of the cost reporting period that occurs during such period.

''(2) NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.—If a reduction in payment amounts is made under subsection (a) for items or services for which payment under part B of such title is made on an assignment-related basis (as defined in section 1842(i)(1) of the Social Security Act [42 U.S.C. 1395u(i)(1)]), the person furnishing the items or services shall be considered to have accepted payment of the reasonable charge for the items or services, less any reduction in payment amount made under subsection (a), as payment in full.

''(3) TREATMENT OF PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS.—Subsection (a) shall not apply to payments under risk-sharing contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] or under similar contracts under section 402 of the Social Security Amendments of 1967 [Pub. L. 90–248, enacting section 1395b–1 of this title and amending section 1395*ll* of this title] or section 222 of the Social Security Amendments of 1972 [Pub. L. 92–603, amending sections 1395b–1 and 1395*ll* of this title and enacting provisions set out as a note under section 1395b–1 of this title].''

EFFECT ON STATE LAW

Conscientious objections of health care provider under State law unaffected by enactment of subsecs. (a)(1)(Q) and (f) of this section, see section 4206(c) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

DEVELOPMENT OF CRITERIA REGARDING CONSULTATION WITH A PHYSICIAN

Pub. L. 101–239, title VI, §6113(c), Dec. 19, 1989, 103 Stat. 2217, as amended by Pub. L. 103–432, title I, §147(b), Oct. 31, 1994, 108 Stat. 4429, provided that: ''The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for qualified psychologist services and clinical social worker services for which payment may be made directly to the psychologist or clinical social worker under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which such a psychologist or clinical social worker must agree to consult with a patient's attending physician in accordance with such criteria.''

[Pub. L. 103–432, title I, §147(b), Oct. 31, 1994, 108 Stat. 4429, provided that the amendment made by that section to section 6113(c) of Pub. L. 101–239, set out above, is effective with respect to services furnished on or after Jan. 1, 1991.]

STUDY OF REIMBURSEMENT FOR AMBULANCE SERVICES

Pub. L. 101–239, title VI, §6136, Dec. 19, 1989, 103 Stat. 2222, directed Secretary of Health and Human Services to conduct a study to determine adequacy and appropriateness of payment amounts under this subchapter for ambulance services and, not later than one year after Dec. 19, 1989, submit a report to Congress on results of the study, with report to include such recommendations for changes in medicare payment policy with respect to ambulance services as may be needed to ensure access by medicare beneficiaries to quality ambulance services in metropolitan and rural areas.

PROPAC STUDY OF PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS

Pub. L. 101–239, title VI, §6137, Dec. 19, 1989, 103 Stat. 2223, directed Prospective Payment Assessment Commission to conduct a study on payment under this subchapter for hospital outpatient services and, not later than July 1, 1990, and not later than Mar. 1, 1991, to submit reports to Congress on specified portions of the study, with the reports to include such recommendations as the Commission deemed appropriate, prior to repeal by Pub. L. 103–432, title I, §147(c)(1), Oct. 31, 1994, 108 Stat. 4429.

BUDGET NEUTRALITY

Pub. L. 100–647, title VIII, §8421(b), Nov. 10, 1988, 102 Stat. 3802, provided that: ''The Secretary of Health and Human Services shall adjust the fees for transportation and personnel established under section 1833(h)(3)(B) of the Social Security Act [42 U.S.C. 1395*l*(h)(3)(B)] for tests not covered under the amendment made by subsection (a) [amending this section] in such manner that the total cost of fees under such section is the same as would have been the case without such amendment.''

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

For requirement that Secretary of Health and Human Services modify contracts under subsection (a)(1)(A) of this section to take into account amendments made by Pub. L. 100–360 and that such organizations make appropriate adjustments in their agreements with medicare beneficiaries to take into account such amendments, see section 222 of Pub. L. 100–360, set out as a note under section 1395mm of this title.

STUDY AND REPORT TO CONGRESS RESPECTING INCENTIVE PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN UNDERSERVED AREAS

Pub. L. 100–203, title IV, §4043(b), Dec. 22, 1987, 101 Stat. 1330–86, directed Secretary of Health and Human Services to study and report to Congress, by not later than Jan. 1, 1990, on feasibility of making additional payments described in section 1395*l*(m) of this title with respect to physician services performed in health manpower shortage areas located in urban areas, prior to repeal by Pub. L. 101–508, title IV, §4118(g)(1), Nov. 5, 1990, 104 Stat. 1388–70.

FEE SCHEDULES FOR PHYSICIAN PATHOLOGY SERVICES

Pub. L. 100–203, title IV, §4050, Dec. 22, 1987, 101 Stat. 1330–92, directed Secretary of Health and Human Serv-

ices to develop a relative value scale and fee schedules with updating index for payment of physician pathology services under this part, and to report to committees of Congress not later than Apr. 1, 1989, on the scale, schedules, and index, prior to repeal by Pub. L. 101–508, title IV, § 4104(b)(3), Nov. 5, 1990, 104 Stat. 1388–59.

APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES

Pub. L. 100–203, title IV, § 4054, Dec. 22, 1987, 101 Stat. 1330–98, relating to payment under part B of title XVIII of the Social Security Act (this part) for physicians' services specified in subsec. (i) of this section and furnished on or after Apr. 1, 1988, in an ambulatory surgical center or hospital outpatient department on an assignment-related basis, was negated in the amendment of section 4054 by Pub. L. 100–360, title IV, § 411(f)(12)(A), July 1, 1988, 102 Stat. 781.

OTHER PHYSICIAN PAYMENT STUDIES

Pub. L. 100–203, title IV, § 4056(c), formerly § 4055(c), Dec. 22, 1987, 101 Stat. 1330–99, as renumbered by Pub. L. 100–360, title IV, § 411(f)(14), July 1, 1988, 102 Stat. 781, provided directed Secretary to (1) conduct a study of changes in the payment system for physicians' services, under part B, that would be required for the implementation of a national fee schedule for such services furnished on or after Jan. 1, 1990, and report to Congress on such study by not later than July 1, 1989, (2) conduct a study of issues relating to the volume and intensity of physicians' services under part B and submit to Congress an interim report on such study not later than May 1, 1988, and a final report on such study not later than May 1, 1989, and (3) conduct a survey to determine distribution of (A) the liabilities and expenditures for health care services of individuals entitled to benefits under this subchapter, including liabilities for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized, and (B) the collection rates among different classes of physicians for such liabilities, including collection rates for required coinsurance and for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized, report to Congress on such study by not later than July 1, 1990.

STUDY OF PAYMENT FOR CHEMOTHERAPY IN PHYSICIANS' OFFICES

Pub. L. 100–203, title IV, § 4056(d), formerly § 4055(d), Dec. 22, 1987, 101 Stat. 1330–99, as renumbered by Pub. L. 100–360, title IV, § 411(f)(14), July 1, 1988, 102 Stat. 781, directed Secretary to study ways of modifying part B to permit adequate payment under such part for costs associated with providing chemotherapy to cancer patients in physicians' offices, with the Secretary to report to Congress on results of study by not later than Apr. 1, 1989, prior to repeal by Pub. L. 105–362, title VI, § 601(b)(7), Nov. 10, 1998, 112 Stat. 3286.

CLINICAL DIAGNOSTIC LABORATORY TESTS; LIMITATION ON CHANGES IN FEE SCHEDULES

Pub. L. 100–203, title IV, § 4064(a), Dec. 22, 1987, 101 Stat. 1330–110, which provided 3-month freeze in fee schedules for clinical laboratory diagnostic laboratory tests under part B of title XVIII of the Social Security Act (this part) and directed the Secretary of Health and Human Services to not adjust the fee schedules established under subsec. (h) of this section to take into account any increase in the consumer price index, was negated in the amendment of section 4064(a) by Pub. L. 100–360, title IV, § 411(g)(3)(A), July 1, 1988, 102 Stat. 783.

GAO STUDY OF FEE SCHEDULES

Pub. L. 100–203, title IV, § 4064(b)(4), Dec. 22, 1987, 101 Stat. 1330–110, directed Comptroller General to conduct a study of level of fee schedules established for clinical diagnostic laboratory services under subsec. (h)(2) of this section to determine, based on costs of, and revenues received for, such tests the appropriateness of such schedules, with Comptroller General to report to Congress on results of such study by not later than Jan. 1, 1990, and with provision that suppliers of such tests which fail to provide Comptroller General with reasonable access to necessary records to carry out study being subject to exclusion from the medicare program under section 1320a–7(a) of this title.

AMOUNTS PAID FOR INDEPENDENT RURAL HEALTH CLINIC SERVICES

Pub. L. 100–203, title IV, § 4067(b), Dec. 22, 1987, 101 Stat. 1330–113, provided that: ''The Secretary of Health and Human Services shall report to Congress, by not later than March 1, 1989, on the adequacy of the amounts paid under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for rural health clinic services provided by independent rural health clinics.''

REPORT ON ESTABLISHMENT OF NATIONAL FEE SCHEDULES FOR PAYMENT OF CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 99–509, title IX, § 9339(b)(3), Oct. 21, 1986, 100 Stat. 2036, directed Secretary of Health and Human Services to report to Congress, by not later than Apr. 1, 1988, on advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests under section 1395*l*(h) of this title, prior to repeal by Pub. L. 101–508, title IV, § 4154(e)(3), Nov. 5, 1990, 104 Stat. 1388–86, effective as if included in enactment of Pub. L. 99–509.

STATE STANDARDS FOR DIRECTORS OF CLINICAL LABORATORIES

Pub. L. 99–509, title IX, § 9339(d), Oct. 21, 1986, 100 Stat. 2037, provided that:

''(1) IN GENERAL.—If a State (as defined for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]) provides for the licensing or other standards with respect to the operation of clinical laboratories (including such laboratories in hospitals) in the State under which such a laboratory may be directed by an individual with certain qualifications, nothing in such title shall be construed as authorizing the Secretary of Health and Human Services to require such a laboratory, as a condition of payment or participation under such title, to be directed by an individual with other qualifications.

''(2) EFFECTIVE DATE.—Paragraph (1) shall take effect on January 1, 1987.''

TRANSITIONAL PROVISIONS FOR PAYMENT OF FEES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 99–272, title IX, § 9303(a)(3), Apr. 7, 1986, 100 Stat. 188, provided that: ''The Secretary of Health and Human Services shall provide that the annual adjustment under section 1833(h) of the Social Security Act [42 U.S.C. 1395*l*(h)] for 1986—

''(A) shall take effect on January 1, 1987,

''(B) shall apply for the 12-month period beginning on that date, and

''(C) shall take into account the percentage increase or decrease in the Consumer Price Index for all urban consumers (United States city average) occurring over an 18-month period, rather than over a 12-month period.''

EXTENSION OF MEDICARE PHYSICIAN PAYMENT PROVISIONS

Amount of payment under this part for physicians' services furnished between Oct. 1, 1985, and Mar. 14, 1986, to be determined on the same basis as the amount of such services furnished on Sept. 30, 1985, see section

5(b) of Pub. L. 99–107, as amended, set out as a note under section 1395ww of this title.

FEE SCHEDULES FOR DIAGNOSTIC LABORATORY TESTS AND FEASIBILITY OF DIRECT PAYMENTS TO PHYSICIANS; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2303(i), July 18, 1984, 98 Stat. 1066, provided that:

''(1) The Comptroller General shall report to the Congress on—

''(A) the appropriateness of the fee schedules under section 1833(h) of the Social Security Act [42 U.S.C. 1395*l*(h)] and their impact on the volume and quality of clinical diagnostic laboratory tests;

''(B) the potential impact of the adoption of a national fee schedule; and

''(C) the potential impact of applying a national fee schedule to clinical diagnostic laboratory tests provided by hospitals to their outpatients.

''(2) The Secretary of Health and Human Services shall report to the Congress with respect to the advisability and feasibility of a system of direct payment to any physician for all clinical diagnostic laboratory tests ordered by such physician.

''(3) The reports required by paragraphs (1) and (2) shall be submitted not later than January 1, 1987.''

PACEMAKER REIMBURSEMENT REVIEW AND REFORM

Pub. L. 98–369, div. B, title III, §2304(a), July 18, 1984, 98 Stat. 1067, provided that:

''(1) The Secretary of Health and Human Services shall issue revisions to the current guidelines for the payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the transtelephonic monitoring of cardiac pacemakers. Such revised guidelines shall include provisions regarding the specifications for and frequency of transtelephonic monitoring procedures which will be found to be reasonable and necessary.

''(2)(A) Except as provided in subparagraph (B), if the guidelines required by paragraph (1) have not been issued and put into effect by October 1, 1984, and until such guidelines have been issued and put into effect, payment may not be made under part B of title XVIII of the Social Security Act for transtelephonic monitoring procedures, with respect to a single-chamber cardiac pacemaker powered by lithium batteries, conducted more frequently than—

''(i) weekly during the first month after implantation,

''(ii) once every two months during the period representing 80 percent of the estimated life of the implanted device, and

''(iii) monthly thereafter.

''(B) Subparagraph (A) shall not apply in cases where the Secretary determines that special medical factors (including possible evidence of pacemaker or lead malfunction) justify more frequent transtelephonic monitoring procedures.''

PAYMENT FOR PREADMISSION DIAGNOSTIC TESTING PERFORMED IN PHYSICIAN'S OFFICE

Pub. L. 98–369, div. B, title III, §2305(f), July 18, 1984, 98 Stat. 1070, provided that: ''The amendments made by this section [amending this section and enacting provisions set out above] shall not be construed as prohibiting payment, subject to the applicable copayments, under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for preadmission diagnostic testing performed in a physician's office to the extent such testing is otherwise reimbursable under regulations of the Secretary.''

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

For provision directing the Secretary to issue regulations requiring providers of services to calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under parts A and B of this subchapter other than diagnostic tests under subsec. (h) of this section, see section 2308(a) of Pub. L. 98–369, set out as a note under section 1395f of this title.

DETERMINATION OF NOMINAL CHARGES FOR APPLYING NOMINALITY TEST

For provision directing the Secretary to provide, in addition to other rules deemed appropriate, that charges representing 60 percent or less of costs be considered nominal for purposes of applying the nominality test under subsec. (a)(2)(B)(ii) of this section, see section 2308(b)(1) of Pub. L. 98–369, set out as a note under section 1395f of this title.

STUDY OF MEDICARE PART B PAYMENTS; COMPILATION OF CENTRALIZED CHARGE DATA BASE; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2309, July 18, 1984, 98 Stat. 1074, directed Director of Office of Technology Assessment to conduct a study of physician reimbursement under the Medicare program and make a report not later than Dec. 31, 1985, covering findings and recommendations on methods by which payment amounts and other program policies under the program might be modified, and directed that Secretary of Health and Human Services compile a centralized Medicare part B charge data base to aid in the study.

MONITORING PROVISION OF HEPATITIS B VACCINE; REVIEW OF CHANGES IN MEDICAL TECHNOLOGY

Pub. L. 98–369, div. B, title III, §2323(e), July 18, 1984, 98 Stat. 1086, provided that: ''The Secretary shall monitor the provision of hepatitis B vaccine under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall review any changes in medical technology which may have an effect on the amounts which should be paid for such service.''

REPORT ON PREADMISSION DIAGNOSTIC TESTING EXPENSES

Pub. L. 96–499, title IX, §932(b), Dec. 5, 1980, 94 Stat. 2635, required a report to Congress, no later than one year after Dec. 5, 1980, on the policy respecting expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital.

STUDY OF FEASIBILITY AND DESIRABILITY OF IMPOSING COPAYMENT REQUIREMENT ON RURAL HEALTH CLINIC VISITS; REPORT NOT LATER THAN DECEMBER 13, 1978

Pub. L. 95–210, §1(c), Dec. 13, 1977, 91 Stat. 1485, directed Secretary of Health, Education, and Welfare to conduct a study of the feasibility and desirability of imposing a copayment for each visit to a rural health clinic for rural health clinic services under this part and that Secretary report to appropriate committee of Congress, not later than one year after Dec. 13, 1977, on such study.

PROHIBITION AGAINST PAYMENTS IN CASES OF NONENTITLEMENT TO MONTHLY BENEFITS UNDER SUBCHAPTER II OR SUSPENSION OF BENEFITS OF ALIENS OUTSIDE THE UNITED STATES

Pub. L. 89–97, title I, §104(b)(1), July 30, 1965, 79 Stat. 334, provided that: ''No payments shall be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to expenses incurred by an individual during any month for which such individual may not be paid monthly benefits under title II of such Act [42 U.S.C. 401 et seq.] (or for which such monthly benefits would be suspended if he were otherwise entitled thereto) by reason of section 202(t) of such Act [42 U.S.C. 402(t)] (relating to suspension of benefits of aliens who are outside the United States).''

§ 1395m. Special payment rules for particular items and services

(a) Payment for durable medical equipment

(1) General rule for payment

(A) In general

With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) Payment basis

Subject to subparagraph (F)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) Exclusive payment rule

Subject to subparagraph (F)(ii), this subsection shall constitute the exclusive provision of this subchapter for payment for covered items under this part or under part A to a home health agency.

(D) Reduction in fee schedules for certain items

With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 45 percent.

(E) Clinical conditions for coverage

(i) In general

The Secretary shall establish standards for clinical conditions for payment for covered items under this subsection.

(ii) Requirements

The standards established under clause (i) shall include the specification of types or classes of covered items that require, as a condition of payment under this subsection, a face-to-face examination of the individual by a physician (as defined in section 1395x(r) of this title), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) and a prescription for the item.

(iii) Priority of establishment of standards

In establishing the standards under this subparagraph, the Secretary shall first establish standards for those covered items for which the Secretary determines there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of documentation to provide for payment of such covered items under this part.

(iv) Standards for power wheelchairs

Effective on December 8, 2003, in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1395x(r)(1) of this title), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) has conducted a face-to-face examination of the individual and written a prescription for the item.

(v) Limitation on payment for covered items

Payment may not be made for a covered item under this subsection unless the item meets any standards established under this subparagraph for clinical condition of coverage.

(F) Application of competitive acquisition; limitation of inherent reasonableness authority

In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1395w–3(a) of this title—

(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

(ii) the Secretary may (and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall) use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1395w–3 of this title and in the case of such adjustment, paragraph (10)(B) shall not be applied; and

(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1395w–3 of this title are recompeted in accordance with section 1395w–3(b)(3)(B) of this title.

(G) Use of information on competitive bid rates

The Secretary shall specify by regulation the methodology to be used in applying the

provisions of subparagraph (F)(ii) and subsection (h)(1)(H)(ii). In promulgating such regulation, the Secretary shall consider the costs of items and services in areas in which such provisions would be applied compared to the payment rates for such items and services in competitive acquisition areas. In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1395u(s)(3)(B) of this title, the Secretary shall—

(i) solicit and take into account stakeholder input; and

(ii) take into account the highest amount bid by a winning supplier in a competitive acquisition area and a comparison of each of the following with respect to non-competitive acquisition areas and competitive acquisition areas:

(I) The average travel distance and cost associated with furnishing items and services in the area.

(II) The average volume of items and services furnished by suppliers in the area.

(III) The number of suppliers in the area.

(H) Diabetic supplies

(i) In general

On or after the date described in clause (ii), the payment amount under this part for diabetic supplies, including testing strips, that are non-mail order items (as defined by the Secretary) shall be equal to the single payment amounts established under the national mail order competition for diabetic supplies under section 1395w–3 of this title.

(ii) Date described

The date described in this clause is the date of the implementation of the single payment amounts under the national mail order competition for diabetic supplies under section 1395w–3 of this title.

(I) Treatment of vacuum erection systems

Effective for items and services furnished on and after July 1, 2015, vacuum erection systems described as prosthetic devices described in section 1395x(s)(8) of this title shall be treated in the same manner as erectile dysfunction drugs are treated for purposes of section 1395w–102(e)(2)(A) of this title.

(2) Payment for inexpensive and other routinely purchased durable medical equipment

(A) In general

Payment for an item of durable medical equipment (as defined in paragraph (13))—

(i) the purchase price of which does not exceed $150,

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,

(iii) which is an accessory used in conjunction with a nebulizer, aspirator, or a ventilator excluded under paragraph (3)(A), or

(iv) in the case of devices furnished on or after October 1, 2015, which serves as a speech generating device or which is an accessory that is needed for the individual to effectively utilize such a device,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

(B) Payment amount

For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes).

(C) Computation of local payment amount and national limited payment amount

For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994, the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the

national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(3) Payment for items requiring frequent and substantial servicing

(A) In general

Payment for a covered item (such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) Payment amount

For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.

(C) Computation of local payment amount and national limited payment amount

For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994, the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(4) Payment for certain customized items

Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this subchapter, shall be made in a lump-sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item.

(5) Payment for oxygen and oxygen equipment

(A) In general

Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), (E), and (F).

(B) Add-on for portable oxygen equipment

When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) Volume adjustment

When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) Limit on adjustment

When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) Recertification for patients receiving home oxygen therapy

In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 56 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.

(F) Rental cap

(i) In general

Payment for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than 36 months.

(ii) Payments and rules after rental cap

After the 36th continuous month during which payment is made for the equipment under this paragraph—

(I) the supplier furnishing such equipment under this subsection shall continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(6) Payment for other covered items (other than durable medical equipment)

Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) Payment for other items of durable medical equipment

(A) Payment

In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) Rental

(I) In general

Except as provided in clause (iii), payment for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

(II) Payment amount

Subject to subclause (III) and subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

(III) Special rule for power-driven wheelchairs

For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting ''15 percent'' and ''6 percent'' for ''10 percent'' and ''7.5 percent'', respectively.

(ii) Ownership after rental

On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item

shall transfer title to the item to the individual.

(iii) Purchase agreement option for complex, rehabilitative power-driven wheelchairs

In the case of a complex, rehabilitative power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

(iv) Maintenance and servicing

After the supplier transfers title to the item under clause (ii) or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(B) Range for rental amounts

(i) For 1989

For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

(ii) For 1990

For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.

(C) Replacement of items

(i) Establishment of reasonable useful lifetime

In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph.

(ii) Payment for replacement items

If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) Length of reasonable useful lifetime

The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this subchapter, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.

(8) Purchase price recognized for miscellaneous devices and items

For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) Computation of local purchase price

Each carrier under section 1395u of this title shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987,

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; [1] or

(III) in 1992, 1993, and 1994, equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.

(B) Computation of national limited purchase price

With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

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

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the median of all local purchase prices computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local purchase prices computed under such subparagraph for the item for the year; and

(iv) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.

(C) Purchase price recognized

For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33 percent of the national limited purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local purchase price computed under subparagraph (A)(ii)(III) for 1992, and (II) 67 percent of the national limited purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited purchase price computed under subparagraph (B) for that year.

(9) Monthly payment amount recognized with respect to oxygen and oxygen equipment

For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an ''item'').

(A) Computation of local monthly payment rate

Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this subchapter.

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991, 1992, 1993, and 1994, equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.

(B) Computation of national limited monthly payment rate

With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local monthly payment rate computed under subparagraph (A)(ii) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) Monthly payment amount recognized

For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; and

(iv) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year.

(D) Authority to create classes

(i) In general

Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

(ii) Budget neutrality

The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken. The requirement of the preceding sentence shall not apply beginning with the second calendar quarter beginning on or after December 27, 2020.

(10) Exceptions and adjustments

(A) Areas outside continental United States

Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) Adjustment for inherent reasonableness

The Secretary is authorized to apply the provisions of paragraphs (8) and (9) of section 1395u(b) of this title to covered items and suppliers of such items and payments under this subsection in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F).

(C) Transcutaneous electrical nerve stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) Improper billing and requirement of physician order

(A) Improper billing for certain rental items

Notwithstanding any other provision of this subchapter, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1395u(j)(2) of this title in the same manner such sanctions may apply with respect to a physician.

(B) Requirement of physician order

(i) In general

The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician enrolled under section 1395cc(j) of this title or an eligible professional under section 1395w–4(k)(3)(B) of this title that is enrolled under section 1395cc(j) of this title has communicated to the supplier, before delivery of the item, a written order for the item.

(ii) Requirement for face to face encounter

The Secretary shall require that such an order be written pursuant to a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

(12) Regional carriers

The Secretary may designate, by regulation under section 1395u of this title, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(13) "Covered item" defined

In this subsection, the term ''covered item'' means durable medical equipment (as defined

in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title, but not including implantable items for which payment may be made under section 1395*l*(t) of this title.

(14) Covered item update

In this subsection, the term ''covered item update'' means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point;

(B) for 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year;

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(E) for 2002, 0 percentage points;

(F) for 2003, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of 2002;

(G) for 2004 through 2006—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage increase described in subparagraph (B) for the year involved; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(H) for 2007—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(I) for 2008—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(J) for 2009—

(i) in the case of items and services furnished in any geographic area, if such items or services were selected for competitive acquisition in any area under the competitive acquisition program under section 1395w–3(a)(1)(B)(i)(I) of this title before July 1, 2008, including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, - 9.5 percent; or

(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2008;

(K) for 2010, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year; and

(L) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(15) Advance determinations of coverage for certain items

(A) Development of lists of items by Secretary

The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

(B) Development of lists of suppliers by Secretary

The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1395y(a)(1) of this title; or

(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

(C) Determinations of coverage in advance

A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1395y(a)(1) of this title if—

(i) the item is included on the list developed by the Secretary under subparagraph (A);

(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.

(16) Disclosure of information and surety bond

The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) with—

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

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

(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000 that the Secretary determines is commensurate with the volume of the billing of the supplier.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1395u(b)(18)(C) of this title) who furnish items or services under this part.

(17) Prohibition against unsolicited telephone contacts by suppliers

(A) In general

A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(B) Prohibiting payment for items furnished subsequent to unsolicited contacts

If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) Exclusion from program for suppliers engaging in pattern of unsolicited contacts

If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this chapter, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1320a–7 of this title.

(18) Refund of amounts collected for certain disallowed items

(A) In general

If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

(B) Sanctions

If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1395u(j)(2) of this title.

(C) Notice

Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) Timely basis defined

A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is

made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19) Certain upgraded items

(A) Individual's right to choose upgraded item

Notwithstanding any other provision of this subchapter, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

(B) Payments to supplier

In the case of the purchase or rental of an upgraded item under subparagraph (A)—

(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

(C) Consumer protection safeguards

Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

(i) determination of fair market prices with respect to an upgraded item;

(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

(iii) conditions of participation for suppliers in the billing arrangement;

(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

(v) such other safeguards as the Secretary determines are necessary.

(20) Identification of quality standards

(A) In general

Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

(i) furnish any such item or service for which payment is made under this part; and

(ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such item or service for which payment may be made under this subchapter.

(B) Designation of independent accreditation organizations

Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1395bb(a) of this title, the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

(C) Quality standards

The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

(D) Items and services described

The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

(i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.

(ii) Prosthetic devices and orthotics and prosthetics described in subsection (h)(4).

(iii) Items and services described in section 1395u(s)(2) of this title.

(E) Implementation

The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, including subparagraph (F), after consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare & Medicaid Services.

(F) Application of accreditation requirement

In implementing quality standards under this paragraph—

(i) subject to clause (ii) and subparagraph (G), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards, except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011; and

(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1395w–4(k)(3)(B) of this title), and including such other persons, such as orthotists and prosthetists, as specified by the Secretary, furnishing such items and services—

(I) such standards and accreditation requirement shall not apply to such professionals and persons unless the Secretary

determines that the standards being applied are designed specifically to be applied to such professionals and persons; and

(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services.

(G) Application of accreditation requirement to certain pharmacies

(i) In general

With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

(ii) Pharmacies described

A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

(I) The total billings by the pharmacy for such items and services under this subchapter are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

(II) The pharmacy has been enrolled under section 1395cc(j) of this title as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.

(21) Special payment rule for specified items and supplies

(A) In general

Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, as identified in the column entitled ''Median FEHP Price'' in the table entitled ''SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS'' included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

(B) Specified item or supply described

For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the HCPCS code for the item or supply is identified in a table referred to in subparagraph (A)(ii).

(C) Application of update to special payment amount

The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1395w–3 of this title.

(22) Special payment rule for diabetic supplies

Notwithstanding the preceding provisions of this subsection, for purposes of determining the payment amount under this subsection for diabetic supplies furnished on or after the first day of the calendar quarter during 2013 that is at least 30 days after January 2, 2013, and before the date described in paragraph (1)(H)(ii), the Secretary shall recalculate and apply the covered item update under paragraph (14) as if subparagraph (J)(i) of such paragraph was amended by striking ''but only if furnished through mail order''.

(b) Fee schedules for radiologist services

(1) Development

The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A), fee schedules (on a regional, statewide, locality, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) Consultation

In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) Considerations

In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

(4) Savings

(A) Budget neutral fee schedules

The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1395*l*(a)(1)(J) and 1395*l*(b) of this title) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) Initial savings

The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under the preliminary fee schedules developed under subparagraph (A).

(C) 1990 fee schedules

For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.

(D) 1991 fee schedules

For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:

(i) National weighted average conversion factor

The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

(ii) Reduced national weighted average

The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) Computation of 1990 locality index relative to national average

The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) Adjusted conversion factor

The adjusted conversion factor for the professional or technical component of a service in a locality is the sum of ½ of the locally-adjusted amount determined under clause (v) and ½ of the GPCI-adjusted amount determined under clause (vi).

(v) Locally-adjusted amount

For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

(vi) GPCI-adjusted amount

For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1395u(b)(14)(C)(iv) of this title for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

(vii) Limits on conversion factor

The conversion factor to be applied to a locality to the professional or technical component of a service shall not be re-

duced under this subparagraph by more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).

(E) Rule for certain scanning services

In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.

(F) Subsequent updating

For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year.

(G) Nonparticipating physicians and suppliers

Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1395u(b)(4)(A)(iv) of this title) of the payment rate recognized for participating physicians and suppliers.

(5) Limiting charges of nonparticipating physicians and suppliers

(A) In general

In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) "Limiting charge" defined

In subparagraph (A), the term ''limiting charge'' means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) Enforcement

If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1395u(j)(2) of this title in the same manner as such sanctions may apply to a physician.

(6) "Radiologist services" defined

For the purposes of this subsection and section 1395*l*(a)(1)(J) of this title, the term ''radiologist services'' only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.

(c) Payment and standards for screening mammography

(1) In general

With respect to expenses incurred for screening mammography (as defined in section 1395x(jj) of this title), payment may be made only—

(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

(B) if the screening mammography is conducted by a facility that has a certificate (or provisional certificate) issued under section 263b of this title.

(2) Frequency covered

(A) In general

Subject to revision by the Secretary under subparagraph (B)—

(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

(ii) payment may be made under this part for only one screening mammography performed on a woman over 34 years of age, but under 40 years of age; and

(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(B) Revision of frequency

(i) Review

The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) Revision of frequency

The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection.

(d) Frequency limits and payment for colorectal cancer screening tests

(1) Screening fecal-occult blood tests

(A) Payment amount

The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-oc-

cult blood tests under section 1395*l*(h) of this title.

(B) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) Screening flexible sigmoidoscopies

(A) Fee schedule

With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1395w–4 of this title shall be consistent with payment under such section for similar or related services.

(B) Payment limit

In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

(C) Facility payment limit

(i) In general

Notwithstanding subsections (i)(2)(A) and (t) of section 1395*l* of this title, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) Limitation on coinsurance

Subject to section 1395*l*(a)(1)(Y) of this title, but notwithstanding any other provision of this subchapter, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) Special rule for detected lesions

Subject to section 1395*l*(a)(1)(Y) of this title, if during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(E) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

(i) if the individual is under 50 years of age; or

(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy.

(3) Screening colonoscopy

(A) Fee schedule

With respect to colorectal cancer screening test consisting of a screening colonoscopy, payment under section 1395w–4 of this title shall be consistent with payment amounts under such section for similar or related services.

(B) Payment limit

In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

(C) Facility payment limit

(i) In general

Notwithstanding subsections (i)(2)(A) and (t) of section 1395*l* of this title, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) Limitation on coinsurance

Subject to section 1395*l*(a)(1)(Y) of this title, but notwithstanding any other provision of this subchapter, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) Special rule for detected lesions

Subject to section 1395*l*(a)(1)(Y) of this title, if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(E) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy.

(e) Accreditation requirement for advanced diagnostic imaging services

(1) In general

(A) In general

Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1395w–4(b) of this title and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).[2]

(B) Advanced diagnostic imaging services defined

In this subsection, the term ''advanced diagnostic imaging services'' includes—

(i) diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); and

(ii) such other diagnostic imaging services, including services described in section 1395w–4(b)(4)(B) of this title (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

(C) Supplier defined

In this subsection, the term ''supplier'' has the meaning given such term in section 1395x(d) of this title.

(2) Accreditation organizations

(A) Factors for designation of accreditation organizations

The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i)[2] and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization's accreditation program.

(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers maintain adherence to the criteria described in paragraph (3).

(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(vi) Such other factors as the Secretary determines appropriate.

(B) Designation

Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) Review and modification of list of accreditation organizations

(i) In general

The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) Special rule for accreditations done prior to removal from list of designated accreditation organizations

In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(3) Criteria for accreditation

The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

(A) standards for qualifications of medical personnel who are not physicians and who

[2] So in original. Subpar. (B) of par. (2) does not contain clauses.

furnish the technical component of advanced diagnostic imaging services;

(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

(E) standards that require the establishment and maintenance of a quality assurance and quality control program by the supplier that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by such supplier; and

(F) any other standards or procedures the Secretary determines appropriate.

(4) Recognition in standards for the evaluation of medical directors and supervising physicians

The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

(B) has attained, through experience, the necessary expertise to be a medical director or a supervising physician;

(C) has completed any continuing medical education courses relating to such services; or

(D) has met such other standards as the Secretary determines appropriate.

(5) Rule for accreditations made prior to designation

In the case of a supplier that is accredited before January 1, 2010, by an accreditation organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.

(f) Reduction in payments for physician pathology services during 1991

(1) In general

For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(2) Limitation

The prevailing charge for the technical and professional components of an[3] physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.

(g) Payment for outpatient critical access hospital services

(1) In general

The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

(2) Election of cost-based hospital outpatient service payment plus fee schedule for professional services

A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1395cc(a)(2)(A) of this title:

(A) Facility fee

With respect to facility services, not including any services for which payment may be made under subparagraph (B), 101 percent of the reasonable costs of the critical access hospital in providing such services.

(B) Fee schedule for professional services

With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services. Subsections (x) and (y) of section 1395*l* of this title shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.

(3) Disregarding charges

The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.

(4) Treatment of clinical diagnostic laboratory services

No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under this part shall apply with respect to clinical

[3] So in original. Probably should be ''a''.

diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this subchapter shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection. For purposes of the preceding sentence and section 1395x(mm)(3) of this title, clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.

(5) Coverage of costs for certain emergency room on-call providers

In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing services covered under this subchapter and are not on-call at any other provider or facility.

(h) Payment for prosthetic devices and orthotics and prosthetics

(1) General rule for payment

(A) In general

Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) Payment basis

Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) Exception for certain public home health agencies

Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(D) Exclusive payment rule

Subject to subparagraph (H)(ii), this subsection shall constitute the exclusive provision of this subchapter for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(E) Exception for certain items

Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of subsection (a)(2).

(F) Special payment rules for certain prosthetics and custom-fabricated orthotics

(i) In general

No payment shall be made under this subsection for an item of custom-fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

(I) furnished by a qualified practitioner; and

(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

(ii) Description of custom-fabricated item

(I) In general

An item described in this clause is an item of custom-fabricated orthotics that requires education, training, and experience to custom-fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

(II) List of items

The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

(iii) Qualified practitioner defined

In this subparagraph, the term ''qualified practitioner'' means a physician or other individual who—

(I) is a qualified physical therapist or a qualified occupational therapist;

(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

(III) in the case of a State that does not provide for the licensing of orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or -fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education

standards that are necessary to provide such prosthetics and orthotics.

(iv) Qualified supplier defined

In this subparagraph, the term ''qualified supplier'' means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

(G) Replacement of prosthetic devices and parts

(i) In general

Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(I) A change in the physiological condition of the patient.

(II) An irreparable change in the condition of the device, or in a part of the device.

(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

(ii) Confirmation may be required if device or part being replaced is less than 3 years old

If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

(I) such determination shall be controlling; and

(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1395y(a)(1)(A) of this title;

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device or replacement part, as the case may be.

(H) Application of competitive acquisition to orthotics; limitation of inherent reasonableness authority

In the case of orthotics described in paragraph (2)(C) of section 1395w–3(a) of this title furnished on or after January 1, 2011, subject to subsection (a)(1)(G), that are included in a competitive acquisition program in a competitive acquisition area under such section—

(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(ii) subject to subsection (a)(1)(G), the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1395w–3 of this title, and in the case of such adjustment, paragraphs (8) and (9) of section 1395u(b) of this title shall not be applied.

(2) Purchase price recognized

For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) Computation of local purchase price

Each carrier under section 1395u of this title shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

(B) Computation of regional purchase price

With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) Purchase price recognized

For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under

subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) Range on amount recognized

The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) Applicability of certain provisions relating to durable medical equipment

Paragraphs (12), (15), and (17) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

(4) Definitions

In this subsection—

(A) the term ''applicable percentage increase'' means—

(i) for 1991, 0 percent;

(ii) for 1992 and 1993, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(iii) for 1994 and 1995, 0 percent;

(iv) for 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(v) for each of the years 1998 through 2000, 1 percent;

(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(vii) for 2002, 1 percent;

(viii) for 2003, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ix) for 2004, 2005, and 2006, 0 percent;

(x) for for[4] each of 2007 through 2010, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year; and

(xi) for 2011 and each subsequent year—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(B) the term ''prosthetic devices'' has the meaning given such term in section 1395x(s)(8) of this title, except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment and does not include an implantable item for which payment may be made under section 1395*l*(t) of this title; and

(C) the term ''orthotics and prosthetics'' has the meaning given such term in section 1395x(s)(9) of this title (and includes shoes described in section 1395x(s)(12) of this title), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title.

(5) Documentation created by orthotists and prosthetists

For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1395w–4(k)(3)(B) of this title.

(i) Payment for surgical dressings

(1) In general

Payment under this subsection for surgical dressings (described in section 1395x(s)(5) of this title) shall be made in a lump sum amount for the purchase of the item in an amount equal to 80 percent of the lesser of—

(A) the actual charge for the item; or

(B) a payment amount determined in accordance with the methodology described in subparagraphs (B) and (C) of subsection (a)(2) (except that in applying such methodology, the national limited payment amount referred to in such subparagraphs shall be initially computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates described in such subsection for 1993 and 1994).

[4] So in original.

(2) Exceptions

Paragraph (1) shall not apply to surgical dressings that are—

(A) furnished as an incident to a physician's professional service; or

(B) furnished by a home health agency.

(j) Requirements for suppliers of medical equipment and supplies

(1) Issuance and renewal of supplier number

(A) Payment

Except as provided in subparagraph (C), no payment may be made under this part after October 31, 1994, for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

(B) Standards for possessing a supplier number

A supplier may not obtain a supplier number unless—

(i) for medical equipment and supplies furnished on or after October 31, 1994, and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

(I) comply with all applicable State and Federal licensure and regulatory requirements;

(II) maintain a physical facility on an appropriate site;

(III) have proof of appropriate liability insurance; and

(IV) meet such other requirements as the Secretary may specify.

(C) Exception for items furnished as incident to a physician's service

Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

(D) Prohibition against multiple supplier numbers

The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(E) Prohibition against delegation of supplier determinations

The Secretary may not delegate (other than by contract under section 1395u of this title) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

(2) Certificates of medical necessity

(A) Limitation on information provided by suppliers on certificates of medical necessity

(i) In general

Effective 60 days after October 31, 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

(II) A description of such medical equipment and supplies.

(III) Any product code identifying such medical equipment and supplies.

(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

(ii) Information on payment amount and charges

If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

(iii) Penalty

Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) "Certificate of medical necessity" defined

For purposes of this paragraph, the term ''certificate of medical necessity'' means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(3) Coverage and review criteria

The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine whether such items should be made subject to coverage and utilization review criteria, and if appro-

priate, shall develop and apply such criteria to such items.

(4) Limitation on patient liability

If a supplier of medical equipment and supplies (as defined in paragraph (5))—

(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

(C) furnishes an item or service to a beneficiary for which payment is denied under section 1395y(a)(1) of this title;

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.

(5) "Medical equipment and supplies" defined

The term ''medical equipment and supplies'' means—

(A) durable medical equipment (as defined in section 1395x(n) of this title);

(B) prosthetic devices (as described in section 1395x(s)(8) of this title);

(C) orthotics and prosthetics (as described in section 1395x(s)(9) of this title);

(D) surgical dressings (as described in section 1395x(s)(5) of this title);

(E) such other items as the Secretary may determine; and

(F) for purposes of paragraphs (1) and (3)—

(i) home dialysis supplies and equipment (as described in section 1395x(s)(2)(F) of this title),

(ii) immunosuppressive drugs (as described in section 1395x(s)(2)(J) of this title),

(iii) therapeutic shoes for diabetics (as described in section 1395x(s)(12) of this title),

(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1395x(s)(2)(Q) of this title), and

(v) self-administered erythropoetin (as described in section 1395x(s)(2)(P) of this title).

(k) Payment for outpatient therapy services and comprehensive outpatient rehabilitation services

(1) In general

With respect to services described in section 1395*l*(a)(8) or 1395*l*(a)(9) of this title for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) Payment in 1998 based upon adjusted reasonable costs

The amount under this paragraph for services is the lesser of—

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

(3) Applicable fee schedule amount

In this subsection, the term ''applicable fee schedule amount'' means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1395w–4 of this title for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) Adjusted reasonable costs

In paragraph (2), the term ''adjusted reasonable costs'' means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1395*l*(a)(8)(B) of this title (relating to services provided by hospitals).

(5) Uniform coding

For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) Restraint on billing

The provisions of subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1395u(b)(18)(C) of this title.

(7) Adjustment in discount for certain multiple therapy services

In the case of therapy services furnished on or after April 1, 2013, and for which payment is made under this subsection pursuant to the applicable fee schedule amount (as defined in paragraph (3)), instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 50 percent.

(*l*) Establishment of fee schedule for ambulance services

(1) In general

The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this

part through a negotiated rulemaking process described in title 5 and in accordance with the requirements of this subsection.

(2) Considerations

In establishing such fee schedule, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner consistent with paragraph (11), except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

(3) Savings

In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points;

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased, subject to subparagraph (C) and the succeeding sentence of this paragraph, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.

(4) Consultation

In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(6) Restraint on billing

The provisions of subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1395u(b)(18)(C) of this title.

(7) Coding system

The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(8) Services furnished by critical access hospitals

Notwithstanding any other provision of this subsection, the Secretary shall pay 101 percent of the reasonable costs incurred in furnishing ambulance services if such services are furnished—

(A) by a critical access hospital (as defined in section 1395x(mm)(1) of this title), or

(B) by an entity that is owned and operated by a critical access hospital,

but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.

(9) Transitional assistance for rural providers

In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) Phase-in providing floor using blend of fee schedule and regional fee schedules

In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1395ww(d)(2) of this title) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) Adjustment in payment for certain long trips

In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.

(12) Assistance for rural providers furnishing services in low population density areas

(A) In general

In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2023, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(B) Identification of qualified rural areas

(i) Determination of population density in area

Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

(ii) Ranking of areas

The Secretary shall rank each such area based on such population density.

(iii) Identification of qualified rural areas

The Secretary shall identify those areas (in subparagraph (A) referred to as ''qualified rural areas'') with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) Rural area

For purposes of this paragraph, the term ''rural area'' has the meaning given such term in section 1395ww(d)(2)(D) of this title. If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) Judicial review

There shall be no administrative or judicial review under section 1395ff, 1395*oo* of this title, or otherwise, respecting the identification of an area under this subparagraph.

(13) Temporary increase for ground ambulance services

(A) In general

After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2023,,[4] for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for

the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023).

(B) Application of increased payments after applicable period

The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the applicable period specified in such subparagraph.

(14) Providing appropriate coverage of rural air ambulance services

(A) In general

The regulations described in section 1395x(s)(7) of this title shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

(ii) complies with equipment and crew requirements established by the Secretary.

(B) Satisfaction of requirement of medically necessary

The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who certifies or reasonably determines that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

(C) Rural air ambulance service defined

For purposes of this paragraph, the term ''rural air ambulance service'' means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(D) Limitation

(i) In general

Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

(ii) Exception

Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1395xx of this title) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

(15) Payment adjustment for non-emergency ambulance transports for ESRD beneficiaries

The fee schedule amount otherwise applicable under the preceding provisions of this subsection shall be reduced by 10 percent for ambulance services furnished during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018, consisting of non-emergency basic life support services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1395rr(b)(14)(B) of this title) furnished other than on an emergency basis by a provider of services or a renal dialysis facility.

(16) Prior authorization for repetitive scheduled non-emergent ambulance transports

(A) In general

Beginning January 1, 2017, if the expansion to all States of the model of prior authorization described in paragraph (2) of section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 meets the requirements described in paragraphs (1) through (3) of section 1315a(c) of this title, then the Secretary shall expand such model to all States.

(B) Funding

The Secretary shall use funds made available under section 1395ddd(h)(10) of this title to carry out this paragraph.

(C) Clarification regarding budget neutrality

Nothing in this paragraph may be construed to limit or modify the application of section 1315a(b)(3)(B) of this title to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning on January 1, 2017, under such subparagraph.

(17) Submission of cost and other information

(A) Development of data collection system

The Secretary shall develop a data collection system (which may include use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services (in this paragraph referred to as ''providers'') and suppliers of ground ambulance services. Such system shall be designed to collect information—

(i) needed to evaluate the extent to which reported costs relate to payment rates under this subsection;

(ii) on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in section 1320a(a) of this title; and

(iii) on different types of ground ambulance services furnished in different geographic locations, including rural areas and low population density areas described in paragraph (12).

(B) Specification of data collection system

(i) In general

The Secretary shall—

(I) not later than December 31, 2019, specify the data collection system under subparagraph (A); and

(II) identify the providers and suppliers of ground ambulance services that would be required to submit information under such data collection system, including the representative sample described in clause (ii).

(ii) Determination of representative sample

(I) In general

Not later than December 31, 2019, with respect to the data collection for the first year under such system, and for each subsequent year through 2024, the Secretary shall determine a representative sample to submit information under the data collection system.

(II) Requirements

The sample under subclause (I) shall be representative of the different types of providers and suppliers of ground ambulance services (such as those providers and suppliers that are part of an emergency service or part of a government organization) and the geographic locations in which ground ambulance services are furnished (such as urban, rural, and low population density areas).

(III) Limitation

The Secretary shall not include an individual provider or supplier of ground ambulance services in the sample under subclause (I) in 2 consecutive years, to the extent practicable.

(C) Reporting of cost information

For each year, a provider or supplier of ground ambulance services identified by the Secretary under subparagraph (B)(i)(II) as being required to submit information under the data collection system with respect to a period for the year shall submit to the Secretary information specified under the system. Such information shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Payment reduction for failure to report

(i) In general

Beginning January 1, 2022, subject to clause (ii), a 10 percent reduction to payments under this subsection shall be made for the applicable period (as defined in clause (ii)) to a provider or supplier of ground ambulance services that—

(I) is required to submit information under the data collection system with respect to a period under subparagraph (C); and

(II) does not sufficiently submit such information, as determined by the Secretary.

(ii) Applicable period defined

For purposes of clause (i), the term ''applicable period'' means, with respect to a provider or supplier of ground ambulance services, a year specified by the Secretary not more than 2 years after the end of the period with respect to which the Secretary has made a determination under clause (i)(II) that the provider or supplier of ground ambulance services failed to sufficiently submit information under the data collection system.

(iii) Hardship exemption

The Secretary may exempt a provider or supplier from the payment reduction under clause (i) with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation that the Secretary determines interfered with the ability of the provider or supplier of ground ambulance services to submit such information in a timely manner for the specified period.

(iv) Informal review

The Secretary shall establish a process under which a provider or supplier of ground ambulance services may seek an informal review of a determination that the provider or supplier is subject to the payment reduction under clause (i).

(E) Ongoing data collection

(i) Revision of data collection system

The Secretary may, as the Secretary determines appropriate and, if available, taking into consideration the report (or reports) under subparagraph (F), revise the data collection system under subparagraph (A).

(ii) Subsequent data collection

In order to continue to evaluate the extent to which reported costs relate to payment rates under this subsection and for

other purposes the Secretary deems appropriate, the Secretary shall require providers and suppliers of ground ambulance services to submit information for years after 2024 as the Secretary determines appropriate, but in no case less often than once every 3 years.

(F) Ground ambulance data collection system study

(i) In general

Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

(ii) Contents

A report under clause (i) shall contain the following:

(I) An analysis of information submitted through the data collection system.

(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).

(IV) Other information determined appropriate by the Commission.

(G) Public availability

The Secretary shall post information on the results of the data collection under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services, as determined appropriate by the Secretary.

(H) Implementation

The Secretary shall implement this paragraph through notice and comment rulemaking.

(I) Administration

Chapter 35 of title 44 shall not apply to the collection of information required under this subsection.

(J) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the data collection system or identification of respondents under this paragraph.

(K) Funding for implementation

For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2018. Amounts transferred under this subparagraph shall remain available until expended.

(m) Payment for telehealth services

(1) In general

Subject to paragraph (8), the Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1395x(r) of this title) or a practitioner (described in section 1395u(b)(18)(C) of this title) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term ''telecommunications system'' includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(2) Payment amount

(A) Distant site

Subject to paragraph (8), the Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this subchapter had such service been furnished without the use of a telecommunications system.

(B) Facility fee for originating site

(i) In general

Subject to clause (ii) and paragraph (6)(C), with respect to a telehealth service, subject to section 1395*l*(a)(1)(U) of this title, there shall be paid to the originating site a facility fee equal to—

(I) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, $20; and

(II) for a subsequent year, the facility fee specified in subclause (I) or this subclause for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year.

(ii) No facility fee if originating site is the home

No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).

(C) Telepresenter not required

Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

(3) Limitation on beneficiary charges

(A) Physician and practitioner

The provisions of section 1395w–4(g) of this title and subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

(B) Originating site

The provisions of section 1395u(b)(18) of this title shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

(4) Definitions

For purposes of this subsection:

(A) Distant site

Subject to paragraph (8), the term ''distant site'' means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

(B) Eligible telehealth individual

The term ''eligible telehealth individual'' means an individual enrolled under this part who receives a telehealth service furnished at an originating site.

(C) Originating site

(i) In general

Except as provided in paragraphs (5), (6), and (7), the term ''originating site'' means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section 254e(a)(1)(A) of this title;

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) Sites described

The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1395x(mm)(1) of this title).

(III) A rural health clinic (as defined in section 1395x(aa)(2) of this title).

(IV) A Federally qualified health center (as defined in section 1395x(aa)(4) of this title).

(V) A hospital (as defined in section 1395x(e) of this title).

(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(VII) A skilled nursing facility (as defined in section 1395i–3(a) of this title).

(VIII) A community mental health center (as defined in section 1395x(ff)(3)(B) of this title).

(IX) A renal dialysis facility, but only for purposes of section 1395rr(b)(3)(B) of this title.

(X) The home of an individual, but only for purposes of section 1395rr(b)(3)(B) of this title or telehealth services described in paragraph (7).

(XI) A rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(D) Physician

The term ''physician'' has the meaning given that term in section 1395x(r) of this title.

(E) Practitioner

The term ''practitioner'' has the meaning given that term in section 1395u(b)(18)(C) of this title.

(F) Telehealth service

(i) In general

Subject to paragraph (8), the term ''telehealth service'' means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) Yearly update

The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

(5) Treatment of home dialysis monthly ESRD-related visit

The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1395rr(b)(3)(B) of this title, at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).

(6) Treatment of stroke telehealth services

(A) Non-application of originating site requirements

The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, as determined by the Secretary.

(B) Inclusion of certain sites

With respect to telehealth services described in subparagraph (A), the term ''originating site'' shall include any hospital (as defined in section 1395x(e) of this title) or critical access hospital (as defined in section 1395x(mm)(1) of this title), any mobile stroke unit (as defined by the Secretary), or any

other site determined appropriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.

(C) No originating site facility fee for new sites

No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).

(7) Treatment of substance use disorder services and mental health services furnished through telehealth

(A) In general

The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after July 1, 2019, to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary, or, on or after the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder, as determined by the Secretary, at an originating site described in paragraph (4)(C)(ii) (other than an originating site described in subclause (IX) of such paragraph).

(B) Requirements for mental health services furnished through telehealth

(i) In general

Payment may not be made under this paragraph for telehealth services furnished by a physician or practitioner to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless such physician or practitioner furnishes an item or service in person, without the use of telehealth, for which payment is made under this subchapter (or would have been made under this subchapter if such individual were entitled to, or enrolled for, benefits under this subchapter at the time such item or service is furnished)—

(I) within the 6-month period prior to the first time such physician or practitioner furnishes such a telehealth service to the eligible telehealth individual; and

(II) during subsequent periods in which such physician or practitioner furnishes such telehealth services to the eligible telehealth individual, at such times as the Secretary determines appropriate.

(ii) Clarification

This subparagraph shall not apply if payment would otherwise be allowed—

(I) under this paragraph (with respect to telehealth services furnished to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder); or

(II) under this subsection without application of this paragraph.

(8) Enhancing telehealth services for Federally qualified health centers and rural health clinics during emergency period

(A) In general

During the emergency period described in section 1320b–5(g)(1)(B) of this title—

(i) the Secretary shall pay for telehealth services that are furnished via a telecommunications system by a Federally qualified health center or a rural health clinic to an eligible telehealth individual enrolled under this part notwithstanding that the Federally qualified health center or rural clinic providing the telehealth service is not at the same location as the beneficiary;

(ii) the amount of payment to a Federally qualified health center or rural health clinic that serves as a distant site for such a telehealth service shall be determined under subparagraph (B); and

(iii) for purposes of this subsection—

(I) the term ''distant site'' includes a Federally qualified health center or rural health clinic that furnishes a telehealth service to an eligible telehealth individual; and

(II) the term ''telehealth services'' includes a rural health clinic service or Federally qualified health center service that is furnished using telehealth to the extent that payment codes corresponding to services identified by the Secretary under clause (i) or (ii) of paragraph (4)(F) are listed on the corresponding claim for such rural health clinic service or Federally qualified health center service.

(B) Special payment rule

(i) In general

The Secretary shall develop and implement payment methods that apply under this subsection to a Federally qualified health center or rural health clinic that serves as a distant site that furnishes a telehealth service to an eligible telehealth individual during such emergency period. Such payment methods shall be based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule under section 1395w–4 of this title. Notwithstanding any other provision of law, the Secretary may implement such payment methods through program instruction or otherwise.

(ii) Exclusion from FQHC PPS calculation and RHC air calculation

Costs associated with telehealth services shall not be used to determine the amount of payment for Federally qualified health center services under the prospective payment system under subsection (*o*) or for

rural health clinic services under the methodology for all-inclusive rates (established by the Secretary) under section 1395*l*(a)(3) of this title.

(n) Authority to modify or eliminate coverage of certain preventive services

Notwithstanding any other provision of this subchapter, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

(1) modify—

(A) the coverage of any preventive service described in subparagraph (A) of section 1395x(ddd)(3) of this title to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

(2) provide that no payment shall be made under this subchapter for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.

***(o)* Development and implementation of prospective payment system**

(1) Development

(A) In general

The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this subchapter. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

(B) Collection of data and evaluation

By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

(2) Implementation

(A) In general

Notwithstanding section 1395*l*(a)(3)(A) of this title, the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this subchapter in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) Payments

(i) Initial payments

The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1395*l*(a)(1)(Z) of this title) under this subchapter for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1395cc(a)(2)(A)(ii) of this title) that would have occurred for such services under this subchapter in such year if the system had not been implemented.

(ii) Payments in subsequent years

Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved; and

(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved.

(C) Preparation for PPS implementation

Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.

(3) Additional payments for certain FQHCS with physicians or other practitioners receiving data 2000 waivers

(A) In general

In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally qualified health center services (as defined in section 1395x(aa)(3) of this title) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in subparagraph (C), the Secretary shall, subject to availability of funds under subparagraph (D), make a payment (at such time and in such manner as specified by the Secretary) to such Federally qualified health center after receiving and approving an application submitted by such Federally qualified health center under subparagraph (B). Such a payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in subparagraph (C)(ii). Such a payment may be made only one time with

respect to each such physician or practitioner.

(B) Application

In order to receive a payment described in subparagraph (A), a Federally qualified health center shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A Federally qualified health center may apply for such a payment for each physician or practitioner described in subparagraph (A) furnishing services described in such subparagraph at such center.

(C) Requirements

For purposes of subparagraph (A), the requirements described in this subparagraph, with respect to a physician or practitioner, are the following:

(i) The physician or practitioner is employed by or working under contract with a Federally qualified health center described in subparagraph (A) that submits an application under subparagraph (B).

(ii) The physician or practitioner first receives a waiver under section 823(g) of title 21 on or after January 1, 2019.

(D) Funding

For purposes of making payments under this paragraph, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $6,000,000, which shall remain available until expended.

(4) Payment for attending physician services furnished by federally qualified health centers to hospice patients

In the case of services described in section 1395d(d)(2)(A)(ii) of this title furnished on or after January 1, 2022, by an attending physician (as defined in section 1395x(dd)(3)(B) of this title, other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a Federally qualified health center, a Federally qualified health center shall be paid for such services under the prospective payment system under this subsection.

(p) Quality incentives to promote patient safety and public health in computed tomography

(1) Quality incentives

In the case of an applicable computed tomography service (as defined in paragraph (2)) for which payment is made under an applicable payment system (as defined in paragraph (3)) and that is furnished on or after January 1, 2016, using equipment that is not consistent with the CT equipment standard (described in paragraph (4)), the payment amount for such service shall be reduced by the applicable percentage (as defined in paragraph (5)).

(2) Applicable computed tomography services defined

In this subsection, the term ''applicable computed tomography service'' means a service billed using diagnostic radiological imaging codes for computed tomography (identified as of January 1, 2014, by HCPCS codes 70450–70498, 71250–71275, 72125–72133, 72191–72194, 73200–73206, 73700–73706, 74150–74178, 74261–74263, and 75571–75574 (and any succeeding codes).[5]

(3) Applicable payment system defined

In this subsection, the term ''applicable payment system'' means the following:

(A) The technical component and the technical component of the global fee under the fee schedule established under section 1395w–4(b) of this title.

(B) The prospective payment system for hospital outpatient department services under section 1395*l*(t) of this title.

(4) Consistency with CT equipment standard

In this subsection, the term ''not consistent with the CT equipment standard'' means, with respect to an applicable computed tomography service, that the service was furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR–29–2013, entitled ''Standard Attributes on CT Equipment Related to Dose Optimization and Management''. Through rulemaking, the Secretary may apply successor standards.

(5) Applicable percentage defined

In this subsection, the term ''applicable percentage'' means—

(A) for 2016, 5 percent; and

(B) for 2017 and subsequent years, 15 percent.

(6) Implementation

(A) Information

The Secretary shall require that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable computed tomography service was furnished that was not consistent with the CT equipment standard (described in paragraph (4)). Such information may be included on a claim and may be a modifier. Such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under subsection (e) and hospitals under section 1395bb(a) of this title.

(B) Administration

Chapter 35 of title 44 shall not apply to information described in subparagraph (A).

(q) Recognizing appropriate use criteria for certain imaging services

(1) Program established

(A) In general

The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

(B) Appropriate use criteria defined

In this subsection, the term ''appropriate use criteria'' means criteria, only developed

[5] So in original. The period probably should be preceded by another closing parenthesis.

or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria shall be evidence-based.

(C) Applicable imaging service defined

In this subsection, the term ''applicable imaging service'' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

(iii) one or more of such mechanisms is available free of charge.

(D) Applicable setting defined

In this subsection, the term ''applicable setting'' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

(E) Ordering professional defined

In this subsection, the term ''ordering professional'' means a physician (as defined in section 1395x(r) of this title) or a practitioner described in section 1395u(b)(18)(C) of this title who orders an applicable imaging service.

(F) Furnishing professional defined

In this subsection, the term ''furnishing professional'' means a physician (as defined in section 1395x(r) of this title) or a practitioner described in section 1395u(b)(18)(C) of this title who furnishes an applicable imaging service.

(2) Establishment of applicable appropriate use criteria

(A) In general

Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

(B) Considerations

In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

(i) have stakeholder consensus;

(ii) are scientifically valid and evidence based; and

(iii) are based on studies that are published and reviewable by stakeholders.

(C) Revisions

The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

(D) Treatment of multiple applicable appropriate use criteria

In the case where the Secretary determines that more than one appropriate use criterion applies with respect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

(3) Mechanisms for consultation with applicable appropriate use criteria

(A) Identification of mechanisms to consult with applicable appropriate use criteria

(i) In general

The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

(ii) Consultation

The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

(iii) Inclusion of certain mechanisms

Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1395w–4(*o*)(4) of this title).

(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

(III) Use of a clinical decision support mechanism established by the Secretary.

(B) Qualified clinical decision support mechanisms

(i) In general

For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

(ii) Requirements

The requirements described in this clause are the following:

(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

(II) In the case where there is more than one applicable appropriate use criterion specified under such paragraph for

an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

(VI) The mechanism meets privacy and security standards under applicable provisions of law.

(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

(C) List of mechanisms for consultation with applicable appropriate use criteria

(i) Initial list

Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

(ii) Periodic updating of list

The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

(4) Consultation with applicable appropriate use criteria

(A) Consultation by ordering professional

Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

(B) Reporting by furnishing professional

Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

(ii) Information regarding—

(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

(II) whether the service ordered would not adhere to such criteria; or

(III) whether such criteria was not applicable to the service ordered.

(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

(C) Exceptions

The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) Emergency services

An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1395dd(e)(1) of this title).

(ii) Inpatient services

An applicable imaging service ordered for an inpatient and for which payment is made under part A.

(iii) Significant hardship

An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

(D) Applicable payment system defined

In this subsection, the term ''applicable payment system'' means the following:

(i) The physician fee schedule established under section 1395w–4(b) of this title.

(ii) The prospective payment system for hospital outpatient department services under section 1395*l*(t) of this title.

(iii) The ambulatory surgical center payment systems under section 1395*l*(i) of this title.

(5) Identification of outlier ordering professionals

(A) In general

With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

(B) Outlier ordering professionals

The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) Use of two years of data

The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) Process

The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

(E) Consultation with stakeholders

The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) Prior authorization for ordering professionals who are outliers

(A) In general

Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) Appropriate use criteria in prior authorization

In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

(C) Funding

For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

(7) Construction

Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

(r) Payment for renal dialysis services for individuals with acute kidney injury

(1) Payment rate

In the case of renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) furnished under this part by a renal dialysis facility or provider of services paid under such section during a year (beginning with 2017) to an individual with acute kidney injury (as defined in paragraph (2)), the amount of payment under this part for such services shall be the base rate for renal dialysis services determined for such year under such section, as adjusted by any applicable geographic adjustment factor applied under subparagraph (D)(iv)(II) of such section and may be adjusted by the Secretary (on a budget neutral basis for payments under this paragraph) by any other adjustment factor under subparagraph (D) of such section.

(2) Individual with acute kidney injury defined

In this subsection, the term ''individual with acute kidney injury'' means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1395rr(b)(14) of this title.

(s) Payment for applicable disposable devices

(1) Separate payment

The Secretary shall make a payment (separate from the payments otherwise made under section 1395fff of this title) in the amount established under paragraph (3) to a home health agency for an applicable disposable device (as defined in paragraph (2)) when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under section 1395fff(b) of this title.

(2) Applicable disposable device

In this subsection, the term applicable disposable device means a disposable device that, as determined by the Secretary, is—

(A) a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy; and

(B) a substitute for, and used in lieu of, a negative pressure wound therapy durable medical equipment item that is an integrated system of a negative pressure vacuum pump, a separate exudate collection canister, and dressings that would otherwise be covered for individuals for such wound therapy.

(3) Payment amount

The separate payment amount established under this paragraph for an applicable disposable device for a year shall be equal to the amount of the payment that would be made under section 1395*l*(t) of this title (relating to payment for covered OPD services) for the year for the Level I Healthcare Common Procedure Coding System (HCPCS) code for which the description for a professional service includes the furnishing of such device.

(t) Site-of-service price transparency

(1) In general

In order to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center under this subchapter, the Secretary shall, for 2018 and each year thereafter, make available to the public via a searchable Internet website, with respect to an appropriate number of such items and services—

(A) the estimated payment amount for the item or service under the outpatient department fee schedule under subsection (t) of section 1395*l* of this title and the ambulatory surgical center payment system under subsection (i) of such section; and

(B) the estimated amount of beneficiary liability applicable to the item or service.

(2) Calculation of estimated beneficiary liability

For purposes of paragraph (1)(B), the estimated amount of beneficiary liability, with respect to an item or service, is the amount for such item or service for which an individual who does not have coverage under a Medicare supplemental policy certified under section 1395ss of this title or any other supplemental insurance coverage is responsible.

(3) Implementation

In carrying out this subsection, the Secretary—

(A) shall include in the notice described in section 1395b–2(a) of this title a notification of the availability of the estimated amounts made available under paragraph (1); and

(B) may utilize mechanisms in existence on December 13, 2016, such as the portion of the Internet website of the Centers for Medicare & Medicaid Services on which information comparing physician performance is posted (commonly referred to as the Physician Compare Internet website), to make available such estimated amounts under such paragraph.

(4) Funding

For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $6,000,000 for fiscal year 2017, to remain available until expended.

(u) Payment and related requirements for home infusion therapy

(1) Payment

(A) Single payment

(i) In general

Subject to clause (iii) and subparagraphs (B) and (C), the Secretary shall implement a payment system under which a single payment is made under this subchapter to a qualified home infusion therapy supplier for items and services described in subparagraphs (A) and (B) of section 1395x(iii)(2))[6] of this title furnished by a qualified home infusion therapy supplier (as defined in section 1395x(iii)(3)(D) of this title) in coordination with the furnishing of home infusion drugs (as defined in section 1395x(iii)(3)(C) of this title) under this part.

(ii) Unit of single payment

A unit of single payment under the payment system implemented under this subparagraph is for each infusion drug administration calendar day in the individual's home. The Secretary shall, as appropriate, establish single payment amounts for types of infusion therapy, including to take into account variation in utilization of nursing services by therapy type.

(iii) Limitation

The single payment amount determined under this subparagraph after application of subparagraph (B) and paragraph (3) shall not exceed the amount determined under the fee schedule under section 1395w–4 of this title for infusion therapy services furnished in a calendar day if furnished in a physician office setting, except such single payment shall not reflect more than 5 hours of infusion for a particular therapy in a calendar day.

(B) Required adjustments

The Secretary shall adjust the single payment amount determined under subparagraph (A) for home infusion therapy services under section 1395x(iii)(1) of this title to reflect other factors such as—

(i) a geographic wage index and other costs that may vary by region; and

(ii) patient acuity and complexity of drug administration.

(C) Discretionary adjustments

(i) In general

Subject to clause (ii), the Secretary may adjust the single payment amount determined under subparagraph (A) (after application of subparagraph (B)) to reflect outlier situations and other factors as the Secretary determines appropriate.

(ii) Requirement of budget neutrality

Any adjustment under this subparagraph shall be made in a budget neutral manner.

(2) Considerations

In developing the payment system under this subsection, the Secretary may consider the costs of furnishing infusion therapy in the home, consult with home infusion therapy suppliers, consider payment amounts for similar items and services under this part and part A, and consider payment amounts established by Medicare Advantage plans under part C and in the private insurance market for home infusion therapy (including average per treatment day payment amounts by type of home infusion therapy).

(3) Annual updates

(A) In general

Subject to subparagraph (B), the Secretary shall update the single payment amount under this subsection from year to year beginning in 2022 by increasing the single payment amount from the prior year by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

(B) Adjustment

For each year, the Secretary shall reduce the percentage increase described in subparagraph (A) by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may re-

[6] So in original. The second closing parenthesis probably should not appear.

sult in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year.

(4) Authority to apply prior authorization

The Secretary may, as determined appropriate by the Secretary, apply prior authorization for home infusion therapy services under section 1395x(iii)(1) of this title.

(5) Accreditation of qualified home infusion therapy suppliers

(A) Factors for designation of accreditation organizations

The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(iii) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(iv) Such other factors as the Secretary determines appropriate.

(B) Designation

Not later than January 1, 2021, the Secretary shall designate organizations to accredit suppliers furnishing home infusion therapy. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) Review and modification of list of accreditation organizations

(i) In general

The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) Special rule for accreditations done prior to removal from list of designated accreditation organizations

In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(D) Rule for accreditations made prior to designation

In the case of a supplier that is accredited before January 1, 2021, by an accreditation organization designated by the Secretary under subparagraph (B) as of January 1, 2019, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2023, for the remaining period such accreditation is in effect.

(6) Notification of infusion therapy options available prior to furnishing home infusion therapy

Prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan described in section 1395x(iii)(1) of this title for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy under this part.

(7) Home infusion therapy services temporary transitional payment

(A) Temporary transitional payment

(i) In general

The Secretary shall, in accordance with the payment methodology described in subparagraph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eligible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1395x(iii)(2))[6] of this title furnished during the period specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

(ii) Period specified

For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

(iii) Transitional home infusion drug defined

For purposes of this paragraph, the term ''transitional home infusion drug'' has the meaning given to the term ''home infusion drug'' under section 1395x(iii)(3)(C))[6] of this title, except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of February 9, 2018.

(B) Payment methodology

For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph (A)(i). Under such payment methodology the Secretary shall—

(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

(ii) assign drugs to such categories, in accordance with such clauses;

(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual's home for drugs assigned to such category.

(C) Payment categories

(i) Payment category 1

The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD number L33794) and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

(ii) Payment category 2

The Secretary shall create a payment category 2 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J1555 JB, J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

(iii) Payment category 3

The Secretary shall create a payment category 3 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, or J9370.

(iv) Infusion drugs not otherwise included

With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

(II) billed under any code that is implemented after February 9, 2018, and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

(D) Payment amounts

(i) In general

Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1395w–4 of this title for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

(ii) Payment amount for category 1

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus three units of HCPCS code 96366 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iii) Payment amount for category 2

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus three units of HCPCS code 96370 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iv) Payment amount for category 3

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one unit of HCPCS code 96413 plus three units of HCPCS code 96415 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(E) Clarifications

(i) Infusion drug administration day

For purposes of this subsection, with respect to the furnishing of transitional home infusion drugs or home infusion drugs to an individual by an eligible home infusion supplier or a qualified home infusion therapy supplier, a reference to payment to such supplier for an infusion drug administration calendar day in the individual's home shall refer to payment only for the date on which professional services (as described in section 1395x(iii)(2)(A) of this title) were furnished to administer such drugs to such individual. For purposes of the previous sentence, an infusion drug administration calendar day shall include all such drugs administered to such individual on such day.

(ii) Treatment of multiple drugs administered on same infusion drug administration day

In the case that an eligible home infusion supplier, with respect to an infusion drug administration calendar day in an in-

dividual's home, furnishes to such individual transitional home infusion drugs which are not all assigned to the same payment category under subparagraph (C), payment to such supplier for such infusion drug administration calendar day in the individual's home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

(F) Eligible home infusion suppliers

In this paragraph, the term ''eligible home infusion supplier'' means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

(G) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(v) Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant

(1) In general

In the case of an outpatient physical therapy service or outpatient occupational therapy service furnished on or after January 1, 2022, for which payment is made under section 1395w–4 of this title or subsection (k), that is furnished in whole or in part by a therapy assistant (as defined by the Secretary), the amount of payment for such service shall be an amount equal to 85 percent of the amount of payment otherwise applicable for the service under this part. Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such services.

(2) Use of modifier

(A) Establishment

Not later than January 1, 2019, the Secretary shall establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined), that the service was furnished by a therapy assistant.

(B) Required use

Each request for payment, or bill submitted, for an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined) on or after January 1, 2020, shall include the modifier established under subparagraph (A) for each such service.

(3) Implementation

The Secretary shall implement this subsection through notice and comment rulemaking.

(w) Opioid use disorder treatment services

(1) In general

The Secretary shall pay to an opioid treatment program (as defined in paragraph (2) of section 1395x(jjj) of this title) an amount that is equal to 100 percent of a bundled payment under this part for opioid use disorder treatment services (as defined in paragraph (1) of such section) that are furnished by such program to an individual during an episode of care (as defined by the Secretary) beginning on or after January 1, 2020. The Secretary shall ensure, as determined appropriate by the Secretary, that no duplicative payments are made under this part or part D for items and services furnished by an opioid treatment program.

(2) Considerations

The Secretary may implement this subsection through one or more bundles based on the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug), the frequency of services, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine[7] appropriate. In developing such bundles, the Secretary may consider payment rates paid to opioid treatment programs for comparable services under State plans under subchapter XIX or under the TRICARE program under chapter 55 of title 10.

(3) Annual updates

The Secretary shall provide an update each year to the bundled payment amounts under this subsection.

(x) Payment rules relating to rural emergency hospitals

(1) Payment for rural emergency hospital services

In the case of rural emergency hospital services (as defined in section 1395x(kkk)(1) of this title), furnished by a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title) on or after January 1, 2023, the amount of payment for such services shall be equal to the amount of payment that would otherwise apply under section 1395*l*(t) of this title for covered OPD services (as defined in section 1395*l*(t)(1)(B) of this title (other than clause (ii) of such section)), increased by 5 percent to reflect the higher costs incurred by such hospitals, and shall include the application of any copayment amount determined under section 1395*l*(t)(8) of this title as if such increase had not occurred.

(2) Additional facility payment

(A) In general

The Secretary shall make monthly payments to a rural emergency hospital in an amount that is equal to 1/12 of the annual additional facility payment specified in subparagraph (B).

[7] So in original. Probably should be ''determines''.

(B) Annual additional facility payment amount

The annual additional facility payment amount specified in this subparagraph is—

(i) for 2023, a Medicare subsidy amount determined under subparagraph (C); and

(ii) for 2024 and each subsequent year, the amount determined under this subparagraph for the preceding year, increased by the hospital market basket percentage increase.

(C) Determination of medicare subsidy amount

For purposes of subparagraph (B)(i), the Medicare subsidy amount determined under this subparagraph is an amount equal to—

(i) the excess (if any) of—

(I) the total amount that the Secretary determines was paid under this subchapter to all critical access hospitals in 2019; over

(II) the estimated total amount that the Secretary determines would have been paid under this subchapter to such hospitals in 2019 if payment were made for inpatient hospital, outpatient hospital, and skilled nursing facility services under the applicable prospective payment systems for such services during such year; divided by

(ii) the total number of such hospitals in 2019.

(D) Reporting on use of the additional facility payment

A rural emergency hospital receiving the additional facility payment under this paragraph shall maintain detailed information as specified by the Secretary as to how the facility has used the additional facility payments. Such information shall be made available to the Secretary upon request.

(3) Payment for ambulance services

For provisions relating to payment for ambulance services furnished by an entity owned and operated by a rural emergency hospital, see subsection (*l*).

(4) Payment for post-hospital extended care services

For provisions relating to payment for post-hospital extended care services furnished by a rural emergency hospital that has a unit that is a distinct part licensed as a skilled nursing facility, see section 1395yy(e) of this title.

(5) Source of payments

(A) In general

Except as provided in subparagraph (B), payments under this subsection shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(B) Additional facility payment and post-hospital extended care services

Payments under paragraph (2) shall be made from the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(y) Payment for attending physician services furnished by rural health clinics to hospice patients

In the case of services described in section 1395d(d)(2)(A)(ii) of this title furnished on or after January 1, 2022, by an attending physician (as defined in section 1395x(dd)(3)(B) of this title, other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a rural health clinic, a rural health clinic shall be paid for such services under the methodology for all-inclusive rates (established by the Secretary) under section 1395*l*(a)(3) of this title, subject to the limits described in section 1395*l*(f) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1834, as added and amended Pub. L. 100–203, title IV, §§4049(a)(2), 4062(b), Dec. 22, 1987, 101 Stat. 1330–91, 1330–100; Pub. L. 100–360, title II, §§202(b)(4), 203(c)(1)(F), 204(b), title IV, §411(a)(3)(A), (B)(ii), (C)(ii), (f)(8)(A), (B)(ii), (D), (g)(1)(A), (B), July 1, 1988, 102 Stat. 704, 722, 726, 768, 779, 781; Pub. L. 100–485, title VI, §608(d)(21)(C), (22)(A), Oct. 13, 1988, 102 Stat. 2420; Pub. L. 101–234, title II, §201(a), title III, §301(b)(1), (c)(1), Dec. 13, 1989, 103 Stat. 1981, 1985; Pub. L. 101–239, title VI, §§6102(f)(1), 6105(a), 6112(a), (c), (d)(1), (e)(2), 6116(b)(2), 6140, Dec. 19, 1989, 103 Stat. 2188, 2210, 2214–2216, 2220, 2224; Pub. L. 101–508, title IV, §§4102(a), (d), (f), 4104(a), 4152(a)(1), (b), (c)(1)–(4)(B)(i), (e), (f)(1), (g)(1), 4153(a)(1), (2)(D), 4163(b), Nov. 5, 1990, 104 Stat. 1388–55, 1388–57, 1388–59, 1388–74, 1388–77 to 1388–81, 1388–83, 1388–97; Pub. L. 103–66, title XIII, §§13542(a), 13543(a), (b), 13544(a)(1), (2), (b)(1), 13545(a), 13546, Aug. 10, 1993, 107 Stat. 587, 589, 590; Pub. L. 103–432, title I, §§102(e), 126(b)(1), (2), (4), (5), (g)(1), (10)(B), 131(a), 132(a), (b), 133(a)(1), 134(a)(1), 135(a)(1), (b)(1), (3), (d)(1), (e)(2)–(5), 145(a), 156(a)(2)(C), Oct. 31, 1994, 108 Stat. 4403, 4414–4416, 4419, 4421–4424, 4427, 4440; Pub. L. 105–33, title IV, §§4101(a), (c), 4104(b)(1), 4105(b)(2), 4201(c)(5), 4312(a), (c), 4316(b), 4531(b)(2), 4541(a)(2), 4551(a), (c)(1), 4552(a), (b), Aug. 5, 1997, 111 Stat. 360, 363, 367, 374, 386, 387, 392, 451, 455, 457–459; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(e)(2), title III, §321(k)(3), title IV, §403(d)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–340, 1501A–366, 1501A–371; Pub. L. 106–554, §1(a)(6) [title I, §§103(b), 104(b), title II, §§201(a), 202(a), 204(a), 205(a), 221(a), 223(b), title IV, §§423(a)(1), (b)(1), 425(a), 426(a), 427(a), 428(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, 2763A–469, 2763A–481, 2763A–482, 2763A–486, 2763A–487, 2763A–518 to 2763A–520, 2763A–522; Pub. L. 108–173, title III, §302(a), (c)(1)(A), (2), (3), (d)(1), (2), title IV, §§405(a)(1), (b)(1), (d)(1), 414(a)–(c)(1), (d), 415(a), title VI, §627(b)(1), title VII, §736(b)(4), (5), Dec. 8, 2003, 117 Stat. 2223, 2230–2232, 2266, 2267, 2278–2281, 2321, 2356; Pub. L. 109–171, title V, §§5101(a)(1), (b)(1), 5113(b), Feb. 8, 2006, 120 Stat. 37, 38, 44; Pub. L. 110–275, title I, §§125(b)(5), 135(a)(1), 144(b)(1), 146(a), (b)(2)(A), 148(a), 149(a), 154(a)(2)(A), (3), (4), (b)(1)(A), (d)(2), July 15, 2008, 122 Stat. 2519, 2532, 2547–2549, 2563, 2564, 2567; Pub. L. 111–72, §1(a), Oct. 13, 2009, 123 Stat. 2059; Pub. L. 111–148, title III, §§3105(a), (c), 3109(a), 3128(a), 3136(a), (b), 3401(j), (m), (n), title IV, §4105(a), title V, §§5501(a)(2), (b)(2), 5502(b), title VI,

§§ 6402(g)(1), 6405(a), 6407(b), 6410(b), title X, §§ 10311(a), (c), 10501(i)(1), (3)(A), Mar. 23, 2010, 124 Stat. 417, 418, 426, 437, 438, 486, 487, 558, 653, 654, 759, 768, 770, 773, 942, 943, 997; Pub. L. 111–309, title I, § 106(a), (c), Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, § 306(a), (c), Dec. 23, 2011, 125 Stat. 1285; Pub. L. 112–96, title III, § 3007(a), (c), Feb. 22, 2012, 126 Stat. 190; Pub. L. 112–240, title VI, §§ 604(a), (c), 633(b), 636, 637, Jan. 2, 2013, 126 Stat. 2347, 2348, 2355–2357; Pub. L. 113–67, div. B, title I, § 1104, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, § 104, title II, § 218(a)(1), (b)(1), Apr. 1, 2014, 128 Stat. 1042, 1063, 1065; Pub. L. 113–295, div. B, title II, § 203, Dec. 19, 2014, 128 Stat. 4065; Pub. L. 114–10, title II, § 203, title V, §§ 504(a), 515(b), Apr. 16, 2015, 129 Stat. 144, 165, 174; Pub. L. 114–27, title VIII, § 808(b), June 29, 2015, 129 Stat. 418; Pub. L. 114–40, § 3, July 30, 2015, 129 Stat. 441; Pub. L. 114–113, div. O, title V, § 504(a), Dec. 18, 2015, 129 Stat. 3021; Pub. L. 114–255, div. A, title IV, § 4011, title V, § 5012(b), div. C, title XVI, § 16008(a), (b)(1), Dec. 13, 2016, 130 Stat. 1186, 1199, 1329; Pub. L. 115–123, div. E, title II, § 50203, title III, §§ 50302(b), 50325, title IV, §§ 50401(a), 50402, 50411, title XII, §§ 53107, 53108, Feb. 9, 2018, 132 Stat. 178, 191, 205, 214, 217, 220, 303; Pub. L. 115–271, title II, §§ 2001(a), 2005(c)(2), title VI, § 6083(a), Oct. 24, 2018, 132 Stat. 3924, 3929, 3994; Pub. L. 116–136, div. A, title III, § 3704, Mar. 27, 2020, 134 Stat. 416; Pub. L. 116–260, div. CC, title I, §§ 121(a), (b)(1), 122(c), 123(a), 125(a)(2)(B), (c), 132, Dec. 27, 2020, 134 Stat. 2955, 2956, 2964, 2966, 2976.)

Applicability of Amendment

Amendment of section by section 125(a)(2)(B), (c) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment notes below.

Editorial Notes

References in Text

Section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (a)(14)(H)(i), is section 302(c)(1)(B) of Pub. L. 108–173, which is set out as a note under this section.

Section 4531(a) of the Balanced Budget Act of 1997, referred to in subsec. (*l*)(3)(A), is section 4531(a) of Pub. L. 105–33, which amended sections 1395u and 1395x of this title.

Section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (*l*)(16)(A), is section 515(a) of Pub. L. 114–10, title V, Apr. 16, 2015, 129 Stat. 174, which relates to the initial expansion of prior authorization model for repetitive scheduled nonemergent ambulance transports and is not classified to the Code.

Codification

Amendment of subsec. (a)(4) by Pub. L. 101–508, § 4152(c)(4)(B)(i), did not become effective pursuant to Pub. L. 101–508, § 4152(c)(4)(B)(ii), because of action of Secretary in developing specific criteria for the treatment of wheelchairs as customized items for purposes of subsec. (a)(4). See Effective Date of 1990 Amendment note below.

Prior Provisions

A prior section 1395m, act Aug. 14, 1935, ch. 531, title XVIII, § 1834, as added July 30, 1965, Pub. L. 89–97, title I, § 102(a), 79 Stat. 303, prescribed limitations on payments for home health services, prior to repeal by Pub. L. 96–499, title IX, § 930(i), Dec. 5, 1980, 94 Stat. 2631, effective with respect to services furnished on or after July 1, 1981.

Amendments

2020—Subsec. (a)(9)(D). Pub. L. 116–260, § 121(b)(1), made technical correction to Pub. L. 105–33, § 4552(b). See 1997 Amendment note below.

Subsec. (a)(9)(D)(ii). Pub. L. 116–260, § 121(a), inserted at end ''The requirement of the preceding sentence shall not apply beginning with the second calendar quarter beginning on or after December 27, 2020.''

Subsec. (d)(2)(C)(ii), (3)(C)(ii). Pub. L. 116–260, § 122(c)(1), substituted ''Subject to section 1395*l*(a)(1)(Y) of this title, but notwithstanding'' for ''Notwithstanding'' in introductory provisions.

Subsec. (d)(2)(D), (3)(D). Pub. L. 116–260, § 122(c)(2), substituted ''Subject to section 1395*l*(a)(1)(Y) of this title, if during'' for ''If during''.

Subsec. (m)(1). Pub. L. 116–136, § 3704(1), substituted ''Subject to paragraph (8), the Secretary'' for ''The Secretary''.

Subsec. (m)(2)(A). Pub. L. 116–136, § 3704(2), substituted ''Subject to paragraph (8), the Secretary'' for ''The Secretary''.

Subsec. (m)(4)(A). Pub. L. 116–136, § 3704(3)(A), substituted ''Subject to paragraph (8), the term'' for ''The term''.

Subsec. (m)(4)(C)(ii)(XI). Pub. L. 116–260, § 125(c), added subcl. (XI).

Subsec. (m)(4)(F)(i). Pub. L. 116–136, § 3704(3)(B), substituted ''Subject to paragraph (8), the term'' for ''The term''.

Subsec. (m)(7). Pub. L. 116–260, § 123(a), substituted ''disorder services and mental health services furnished through telehealth'' for ''disorder services furnished through telehealth'' in heading, designated existing provisions as subpar. (A) and inserted heading, inserted ''or, on or after the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder, as determined by the Secretary,'' after ''as determined by the Secretary,'', and added subpar. (B).

Subsec. (m)(8). Pub. L. 116–136, § 3704(4), added par. (8).

Subsec. (*o*)(4). Pub. L. 116–260, § 132(1), added par. (4).

Subsec. (x). Pub. L. 116–260, § 125(a)(2)(B), added subsec. (x).

Subsec. (y). Pub. L. 116–260, § 132(2), added subsec. (y).

2018—Subsec. (a)(2)(A)(iv). Pub. L. 115–123, § 50411, struck out ''and before October 1, 2018,'' after ''October 1, 2015,''.

Subsec. (h)(5). Pub. L. 115–123, § 50402, added par. (5).

Subsec. (*l*)(12)(A). Pub. L. 115–123, § 50203(a)(2), substituted ''2023'' for ''2018''.

Subsec. (*l*)(13)(A). Pub. L. 115–123, § 50203(a)(1), substituted ''2023'' for ''2018'' wherever appearing.

Subsec. (*l*)(15). Pub. L. 115–123, § 53108, substituted ''during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018'' for ''on or after October 1, 2013''.

Subsec. (*l*)(17). Pub. L. 115–123, § 50203(b), added par. (17).

Subsec. (m)(2)(B). Pub. L. 115–123, § 50302(b)(2), redesignated existing provisions as cl. (i), inserted heading, substituted ''Subject to clause (ii), with respect to'' for ''With respect to'', redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, of cl. (i), substituted ''subclause (I) or this subclause'' for ''clause (i) or this clause'' in subcl. (II), and added cl. (ii).

Subsec. (m)(2)(B)(i). Pub. L. 115–271, § 2001(a)(1)(A), substituted ''clause (ii) and paragraph (6)(C)'' for ''clause (ii)'' in introductory provisions.

Subsec. (m)(2)(B)(ii). Pub. L. 115–271, § 2001(a)(1)(B), struck out ''for home dialysis therapy'' after ''site'' in heading.

Subsec. (m)(4)(C)(i). Pub. L. 115–271, § 2001(a)(2)(A), substituted ''paragraphs (5), (6), and (7)'' for ''paragraph (6)'' in introductory provisions.

Pub. L. 115–123, §50325(1), substituted ''Except as provided in paragraph (6), the term'' for ''The term'' in introductory provisions.

Subsec. (m)(4)(C)(ii)(IX). Pub. L. 115–123, §50302(b)(1)(A), added subcl. (IX).

Subsec. (m)(4)(C)(ii)(X). Pub. L. 115–271, §2001(a)(2)(B), inserted ''or telehealth services described in paragraph (7)'' before period at end.

Pub. L. 115–123, §50302(b)(1)(A), added subcl. (X).

Subsec. (m)(5). Pub. L. 115–123, §50302(b)(1)(B), added par. (5).

Subsec. (m)(6). Pub. L. 115–123, §50325(2), added par. (6).

Subsec. (m)(7). Pub. L. 115–271, §2001(a)(3), added par. (7).

Subsec. (*o*)(3). Pub. L. 115–271, §6083(a), added par. (3).

Subsec. (u)(7). Pub. L. 115–123, §50401(a), added par. (7).

Subsec. (v). Pub. L. 115–123, §53107, added subsec. (v).

Subsec. (w). Pub. L. 115–271, §2005(c)(2), added subsec. (w).

2016—Subsec. (a)(1)(G). Pub. L. 114–255, §16008(a), inserted at end ''In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1395u(s)(3)(B) of this title, the Secretary shall—'' and added cls. (i) and (ii).

Subsec. (h)(1)(H)(ii). Pub. L. 114–255, §16008(b)(1), substituted ''subject to subsection (a)(1)(G), the Secretary'' for ''the Secretary''.

Subsec. (t). Pub. L. 114–255, §4011, added subsec. (t).

Subsec. (u). Pub. L. 114–255, §5012(b), added subsec. (u).

2015—Subsec. (a)(2)(A)(iv). Pub. L. 114–40 added cl. (iv).

Subsec. (a)(11)(B)(ii). Pub. L. 114–10, §504(a), struck out ''the physician documenting that'' after ''written pursuant to'' and substituted ''documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter'' for ''has had a face-to-face encounter''.

Subsec. (*l*)(12)(A). Pub. L. 114–10, §203(b), substituted ''January 1, 2018'' for ''April 1, 2015''.

Subsec. (*l*)(13)(A). Pub. L. 114–10, §203(a), substituted ''January 1, 2018'' for ''April 1, 2015'' wherever appearing.

Subsec. (*l*)(16). Pub. L. 114–10, §515(b), added par. (16).

Subsec. (r). Pub. L. 114–27 added subsec. (r).

Subsec. (s). Pub. L. 114–113 added subsec. (s).

2014—Subsec. (a)(1)(I). Pub. L. 113–295 added subpar. (I).

Subsec. (*l*)(12)(A). Pub. L. 113–93, §104(b), substituted ''April 1, 2015'' for ''April 1, 2014''.

Subsec. (*l*)(13)(A). Pub. L. 113–93, §104(a), substituted ''April 1, 2015'' for ''April 1, 2014'' wherever appearing.

Subsec. (p). Pub. L. 113–93, §218(a)(1), added subsec. (p).

Subsec. (q). Pub. L. 113–93, §218(b)(1), added subsec. (q).

2013—Subsec. (a)(1)(F). Pub. L. 112–240, §636(a)(1), substituted ''subparagraphs (G) and (H)'' for ''subparagraph (G)'' in introductory provisions.

Subsec. (a)(1)(H). Pub. L. 112–240, §636(a)(2), added subpar. (H).

Subsec. (a)(22). Pub. L. 112–240, §636(b), added par. (22).

Subsec. (k)(7). Pub. L. 112–240, §633(b), added par. (7).

Subsec. (*l*)(12)(A). Pub. L. 113–67, §1104(b), substituted ''April 1, 2014'' for ''January 1, 2014''.

Pub. L. 112–240, §604(c), substituted ''January 1, 2014'' for ''January 1, 2013''.

Subsec. (*l*)(13)(A). Pub. L. 113–67, §1104(a), substituted ''April 1, 2014'' for ''January 1, 2014'' wherever appearing.

Pub. L. 112–240, §604(a), substituted ''January 1, 2014'' for ''January 1, 2013'' wherever appearing.

Subsec. (*l*)(15). Pub. L. 112–240, §637, added par. (15).

2012—Subsec. (*l*)(12)(A). Pub. L. 112–96, §3007(c), substituted ''January 1, 2013'' for ''March 1, 2012''.

Subsec. (*l*)(13)(A). Pub. L. 112–96, §3007(a), substituted ''January 1, 2013'' for ''March 1, 2012'' wherever appearing.

2011—Subsec. (*l*)(12)(A). Pub. L. 112–78, §306(c), substituted ''March 1, 2012'' for ''January 1, 2012''.

Subsec. (*l*)(13)(A). Pub. L. 112–78, §306(a), substituted ''March 1, 2012'' for ''January 1, 2012'' wherever appearing.

2010—Subsec. (a)(1)(F)(ii). Pub. L. 111–148, §6410(b)(2)(A), inserted ''(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)'' after ''may''.

Subsec. (a)(1)(F)(iii). Pub. L. 111–148, §6410(b)(1), (2)(B), (3), added cl. (iii).

Subsec. (a)(7)(A)(i)(II). Pub. L. 111–148, §3136(a)(1)(A), inserted ''subclause (III) and'' after ''Subject to''.

Subsec. (a)(7)(A)(i)(III). Pub. L. 111–148, §3136(a)(1)(B), added subcl. (III).

Subsec. (a)(7)(A)(iii). Pub. L. 111–148, §3136(a)(2)(B), inserted ''complex, rehabilitative'' after ''case of a''.

Pub. L. 111–148, §3136(a)(2)(A), inserted ''complex, rehabilitative'' after ''option for'' in heading.

Subsec. (a)(7)(C)(ii)(II). Pub. L. 111–148, §3136(b), struck out ''(A)(ii) or'' after ''subparagraph''.

Subsec. (a)(11)(B). Pub. L. 111–148, §6407(b)(1), designated existing provisions as cl. (i) and inserted heading.

Pub. L. 111–148, §6405(a), substituted ''physician enrolled under section 1395cc(j) of this title or an eligible professional under section 1395w–4(k)(3)(B) of this title that is enrolled under section 1395cc(j) of this title'' for ''physician''.

Subsec. (a)(11)(B)(ii). Pub. L. 111–148, §6407(b)(2), added cl. (ii).

Subsec. (a)(14). Pub. L. 111–148, §3401(m)(3), inserted concluding provisions.

Subsec. (a)(14)(K). Pub. L. 111–148, §3401(m)(1), struck out ''2011, 2012, and 2013,'' after ''2010,'' and inserted ''and'' at the end.

Subsec. (a)(14)(L), (M). Pub. L. 111–148, §3401(m)(2), added subpar. (L) and struck out former subpars. (L) and (M) which read as follows:

''(L) for 2014—

''(i) in the case of items and services described in subparagraph (J)(i) for which a payment adjustment has not been made under subsection (a)(1)(F)(ii) in any previous year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013, plus 2.0 percentage points; or

''(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013; and

''(M) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''

Subsec. (a)(16)(B). Pub. L. 111–148, §6402(g)(1), inserted ''that the Secretary determines is commensurate with the volume of the billing of the supplier'' after ''$50,000''.

Subsec. (a)(20)(F)(i). Pub. L. 111–148, §3109(a)(1)(B), which directed amendment by inserting '', except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011'' before semicolon ''at the end'', was executed by making the insertion before ''; and'' to reflect the probable intent of Congress.

Pub. L. 111–148, §3109(a)(1)(A), inserted ''and subparagraph (G)'' after ''clause (ii)''.

Subsec. (a)(20)(G). Pub. L. 111–148, §3109(a)(2), added subpar. (G).

Subsec. (g)(2)(A). Pub. L. 111–148, §3128(a), inserted ''101 percent of'' after ''subparagraph (B),''.

Subsec. (g)(2)(B). Pub. L. 111–148, §5501(b)(2), substituted ''Subsections (x) and (y) of section 1395*l*'' for ''Section 1395*l*(x)''.

Pub. L. 111–148, §5501(a)(2), inserted at end ''Section 1395*l*(x) of this title shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''

Subsec. (h)(4)(A). Pub. L. 111–148, §3401(n)(1)(D), inserted concluding provisions.

Subsec. (h)(4)(A)(x). Pub. L. 111–148, § 3401(n)(1)(B)(i), substituted ''for each of 2007 through 2010'' for ''a subsequent year''.

Subsec. (h)(4)(A)(xi). Pub. L. 111–148, § 3401(n)(1)(A), (B)(ii), (C), added cl. (xi).

Subsec. (*l*)(3). Pub. L. 111–148, § 3401(j)(4), inserted concluding provisions.

Subsec. (*l*)(3)(B). Pub. L. 111–148, § 3401(j)(2)(A), inserted '', subject to subparagraph (C) and the succeeding sentence of this paragraph,'' after ''increased''.

Subsec. (*l*)(3)(C). Pub. L. 111–148, § 3401(j)(1), (2)(B), (3), added subpar. (C).

Subsec. (*l*)(8). Pub. L. 111–148, § 3128(a), inserted ''101 percent of'' after ''pay'' in introductory provisions.

Subsec. (*l*)(12)(A). Pub. L. 111–309, § 106(c), substituted ''2012'' for ''2011''.

Pub. L. 111–148, § 10311(c), substituted ''2011'' for ''2010, and on or after April 1, 2010, and before January 1, 2011''.

Pub. L. 111–148, § 3105(c), substituted ''2010, and on or after April 1, 2010, and before January 1, 2011'' for ''2010''.

Subsec. (*l*)(13)(A). Pub. L. 111–309, § 106(a)(1), substituted ''2012,'' for ''2011'' in introductory provisions.

Pub. L. 111–148, § 10311(a)(1), in introductory provisions, substituted ''2007, and for'' for ''2007, for'' and ''2011'' for ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011''.

Pub. L. 111–148, § 3105(a)(1), in introductory provisions, substituted ''2007, for'' for ''2007, and for'' and ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,'' for ''2010''.

Subsec. (*l*)(13)(A)(i), (ii). Pub. L. 111–309, § 106(a)(2), substituted ''January 1, 2012'' for ''January 1, 2011''.

Pub. L. 111–148, § 10311(a)(2)(B), substituted ''January 1, 2011'' for ''January 1, 2010''.

Pub. L. 111–148, § 10311(a)(2)(A), struck out '', and on or after April 1, 2010, and before January 1, 2011'' after ''January 1, 2010''.

Pub. L. 111–148, § 3105(a)(2), inserted '', and on or after April 1, 2010, and before January 1, 2011'' after ''January 1, 2010''.

Subsec. (n). Pub. L. 111–148, § 5502(b), which directed the addition of subsec. (n) relating to development and implementation of prospective payment system, was repealed by Pub. L. 111–148, § 10501(i)(1).

Pub. L. 111–148, § 4105(a), added subsec. (n) relating to authority to modify or eliminate coverage of certain preventive services.

Subsec. (*o*). Pub. L. 111–148, § 10501(i)(3)(A), added subsec. (*o*).

2009—Subsec. (a)(20)(F)(i). Pub. L. 111–72 inserted '', except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010'' before semicolon.

2008—Subsec. (a)(1)(E)(ii). Pub. L. 110–275, § 154(d)(2), substituted ''1395x(r)'' for ''1395x(r)(1)''.

Subsec. (a)(1)(F). Pub. L. 110–275, § 154(a)(3), (4)(A)(i), in introductory provisions, substituted ''January 1, 2011'' for ''January 1, 2009'' and inserted ''subject to subparagraph (G),'' before ''that are included''.

Subsec. (a)(1)(G). Pub. L. 110–275, § 154(a)(4)(A)(ii), added subpar. (G).

Subsec. (a)(5)(F). Pub. L. 110–275, § 144(b)(1), substituted ''Rental cap'' for ''Ownership of equipment'' in heading, added cl. (ii), and struck out former cl. (ii) which related to transfer of title to equipment and payments for oxygen and maintenance and servicing.

Subsec. (a)(14)(J) to (M). Pub. L. 110–275, § 154(a)(2)(A), added subpars. (J) to (L) and redesignated former subpar. (J) as (M).

Subsec. (a)(20)(B). Pub. L. 110–275, § 125(b)(5), substituted ''section 1395bb(a)'' for ''section 1395bb(b)''.

Subsec. (a)(20)(E). Pub. L. 110–275, § 154(b)(1)(A)(i), inserted ''including subparagraph (F),'' after ''under this paragraph,''.

Subsec. (a)(20)(F). Pub. L. 110–275, § 154(b)(1)(A)(ii), added subpar. (F).

Subsec. (e). Pub. L. 110–275, § 135(a)(1), added subsec. (e).

Subsec. (g)(4). Pub. L. 110–275, § 148(a), substituted ''Treatment of'' for ''No beneficiary cost-sharing for'' in heading and inserted at end ''For purposes of the preceding sentence and section 1395x(mm)(3) of this title, clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.''

Subsec. (h)(1)(H). Pub. L. 110–275, § 154(a)(3), (4)(B), in introductory provisions, substituted ''January 1, 2011'' for ''January 1, 2009'' and inserted ''subject to subsection (a)(1)(G),'' before ''that are included''.

Subsec. (*l*)(13)(A). Pub. L. 110–275, § 146(a)(1), inserted ''and for such services furnished on or after July 1, 2008, and before January 1, 2010'' after ''2007,'' in introductory provisions, ''(or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)'' after ''2 percent'' in cl. (i), and ''(or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)'' after ''1 percent'' in cl. (ii).

Subsec. (*l*)(13)(B). Pub. L. 110–275, § 146(a)(2), substituted ''applicable period'' for ''2006'' in heading and inserted ''applicable'' before ''period'' in text.

Subsec. (*l*)(14)(B)(i). Pub. L. 110–275, § 146(b)(2)(A), substituted ''certifies or reasonably determines'' for ''reasonably determines or certifies''.

Subsec. (m)(4)(C)(ii)(VI) to (VIII). Pub. L. 110–275, § 149(a), added subcls. (VI) to (VIII).

2006—Subsec. (a)(5)(A). Pub. L. 109–171, § 5101(b)(1)(A), substituted ''(E), and (F)'' for ''and (E)''.

Subsec. (a)(5)(F). Pub. L. 109–171, § 5101(b)(1)(B), added subpar. (F).

Subsec. (a)(7)(A). Pub. L. 109–171, § 5101(a)(1), amended heading and text of subpar. (A) generally, revising and restating as cls. (i) to (iv) provisions of former cls. (i) to (vi).

Subsec. (d)(2)(C)(ii). Pub. L. 109–171, § 5113(b), struck out ''deductible and'' before ''coinsurance'' in heading and struck out ''deductible or'' before ''copayment'' and before ''coinsurance'' in subcl. (I).

Subsec. (d)(3)(C)(ii). Pub. L. 109–171, § 5113(b), struck out ''deductible and'' before ''coinsurance'' in heading and struck out ''deductible or'' before ''coinsurance'' in two places in subcl. (I).

2003—Subsec. (a)(1)(B). Pub. L. 108–173, § 302(d)(1)(A), substituted ''Subject to subparagraph (F)(i), the payment basis'' for ''The payment basis'' in introductory provisions.

Subsec. (a)(1)(C). Pub. L. 108–173, § 302(d)(1)(B), substituted ''Subject to subparagraph (F)(ii), this subsection'' for ''This subsection''.

Subsec. (a)(1)(E). Pub. L. 108–173, § 302(a)(2), added subpar. (E).

Subsec. (a)(1)(F). Pub. L. 108–173, § 302(d)(1)(C), added subpar. (F).

Subsec. (a)(10)(B). Pub. L. 108–173, § 302(d)(1)(D), inserted ''in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F)'' after ''under this subsection''.

Subsec. (a)(14)(F). Pub. L. 108–173, § 302(c)(1)(A)(ii), substituted ''2003'' for ''a subsequent year'' and ''2002;'' for ''the previous year.''

Subsec. (a)(14)(G) to (J). Pub. L. 108–173, § 302(c)(1)(A)(i), (iii), added subpars (G) to (J).

Subsec. (a)(17), (19). Pub. L. 108–173, § 302(a)(1)(A), redesignated par. (17), relating to certain upgraded items, as (19) and transferred it to the end of subsec. (a).

Subsec. (a)(20). Pub. L. 108–173, § 302(a)(1)(B), added par. (20).

Subsec. (a)(21). Pub. L. 108–173, § 302(c)(2), added par. (21).

Subsec. (b)(4)(D)(iv). Pub. L. 108–173, § 736(b)(4), substituted ''clause (vi)'' for ''clauses (vi)''.

Subsec. (g)(1). Pub. L. 108–173, § 405(a)(1), inserted ''equal to 101 percent of'' before ''the reasonable costs''.

Subsec. (g)(2). Pub. L. 108–173, §405(d)(1), inserted concluding provisions.

Subsec. (g)(5). Pub. L. 108–173, §405(b)(1), in heading, inserted ''certain'' before ''emergency'' and substituted ''providers'' for ''physicians'', and, in text, substituted ''physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services'' for ''emergency room physicians who are on-call (as defined by the Secretary)'' and ''services covered under this subchapter'' for ''physicians' services''.

Subsec. (h)(1)(B). Pub. L. 108–173, §302(d)(2)(A), substituted '', (E), and (H)(i)'' for ''and (E)'' in introductory provisions.

Subsec. (h)(1)(D). Pub. L. 108–173, §302(d)(2)(B), substituted ''Subject to subparagraph (H)(ii), this subsection'' for ''This subsection''.

Subsec. (h)(1)(H). Pub. L. 108–173, §302(d)(2)(C), added subpar. (H).

Subsec. (h)(4)(A)(viii). Pub. L. 108–173, §302(c)(3)(B), substituted ''2003'' for ''a subsequent year''.

Subsec. (h)(4)(A)(ix), (x). Pub. L. 108–173, §302(c)(3)(A), (C), added cls. (ix) and (x).

Subsec. (h)(4)(C). Pub. L. 108–173, §627(b)(1), inserted ''(and includes shoes described in section 1395x(s)(12) of this title)'' after ''in section 1395x(s)(9) of this title''.

Subsec. (*l*)(2)(E). Pub. L. 108–173, §414(a)(1), inserted ''consistent with paragraph (11)'' after ''in an efficient and fair manner''.

Subsec. (*l*)(8), (9). Pub. L. 108–173, §414(a)(2), redesignated par. (8), relating to transitional assistance for rural providers, as (9).

Subsec. (*l*)(10). Pub. L. 108–173, §414(a)(3), added par. (10).

Subsec. (*l*)(11). Pub. L. 108–173, §414(b), added par. (11).

Subsec. (*l*)(12). Pub. L. 108–173, §414(c)(1), added par. (12).

Subsec. (*l*)(13). Pub. L. 108–173, §414(d), added par. (13).

Subsec. (*l*)(14). Pub. L. 108–173, §415(a), added par. (14).

Subsec. (m)(4)(C)(ii)(III). Pub. L. 108–173, §736(b)(5), substituted ''1395x(aa)(2)'' for ''1395x(aa)(s)''.

2000—Subsec. (a)(14)(C). Pub. L. 106–554, §1(a)(6) [title IV, §425(a)(2)], substituted ''through 2000'' for ''through 2002'' and struck out ''and'' at end.

Subsec. (a)(14)(D) to (F). Pub. L. 106–554, §1(a)(6) [title IV, §425(a)(1), (3)], added subpars. (D) and (E) and redesignated former subpar. (D) as (F).

Subsec. (c). Pub. L. 106–554, §1(a)(6) [title I, §104(b)], amended heading and text generally, substituting present provisions for provisions which had set forth similar standards for screening mammography but had provided for payment limited to 80 percent of the least of the actual charge, a statutory fee schedule, if applicable, or the indexed dollar limit described, and which had set forth provisions relating to reduction of indexed dollar limit, application of limit in a hospital outpatient setting, and limitation of charges of nonparticipating physicians.

Subsec. (d)(2)(E)(ii). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(1)], inserted before period at end ''or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy''.

Subsec. (d)(3). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(A)], struck out ''for individuals at high risk for colorectal cancer'' after ''colonoscopy'' in heading.

Subsec. (d)(3)(A). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(B)], struck out ''for individuals at high risk for colorectal cancer (as defined in section 1395x(pp)(2) of this title)'' after ''screening colonoscopy''.

Subsec. (d)(3)(E). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(C)], inserted before period at end ''or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy''.

Subsec. (g)(2)(B). Pub. L. 106–554, §1(a)(6) [title II, §202(a)], inserted ''115 percent of'' before ''such amounts''.

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title II, §201(a)], added par. (4).

Subsec. (g)(5). Pub. L. 106–554, §1(a)(6) [title II, §204(a)], added par. (5).

Subsec. (h)(1)(F). Pub. L. 106–554, §1(a)(6) [title IV, §427(a)], added subpar. (F).

Subsec. (h)(1)(G). Pub. L. 106–554, §1(a)(6) [title IV, §428(a)], added subpar. (G).

Subsec. (h)(4)(A)(v). Pub. L. 106–554, §1(a)(6) [title IV, §426(a)(2)], substituted ''through 2000'' for ''through 2002'' and struck out ''and'' at end.

Subsec. (h)(4)(A)(vi) to (viii). Pub. L. 106–554, §1(a)(6) [title IV, §426(a)(1), (3)], added cls. (vi) and (vii) and redesignated former cl. (vi) as (viii).

Subsec. (*l*)(2)(E). Pub. L. 106–554, §1(a)(6) [title IV, §423(b)(1)], inserted before period at end '', except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported''.

Subsec. (*l*)(3)(A), (B). Pub. L. 106–554, §1(a)(6) [title IV, §423(a)(1)], substituted ''reduced in the case of 2002'' for ''reduced in the case of 2001 and 2002''.

Subsec. (*l*)(8). Pub. L. 106–554, §1(a)(6) [title II, §221(a)], added par. (8) relating to transitional assistance for rural providers.

Pub. L. 106–554, §1(a)(6) [title II, §205(a)], added par. (8) relating to services furnished by critical access hospitals.

Subsec. (m). Pub. L. 106–554, §1(a)(6) [title II, §223(b)], added subsec. (m).

1999—Subsec. (a)(13). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(2)(A)], substituted ''1395x(m)(5) of this title, but not including implantable items for which payment may be made under section 1395*l*(t) of this title'' for ''1395x(m)(5) of this title)''.

Subsec. (g). Pub. L. 106–113, §1000(a)(6) [title IV, §403(d)(1)], amended heading and text of subsec. (g) generally. Prior to amendment, text read as follows: ''The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''

Subsec. (h)(4)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(3)(A)], substituted semicolon for comma at end.

Subsec. (h)(4)(A)(v). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(3)(B)], substituted ''; and'' for '', and'' at end.

Subsec. (h)(4)(B). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(2)(B)], inserted ''and does not include an implantable item for which payment may be made under section 1395*l*(t) of this title'' before the semicolon.

1997—Subsec. (a)(2)(B)(iv). Pub. L. 105–33, §4105(b)(2), inserted before period at end ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

Subsec. (a)(9)(B)(iv). Pub. L. 105–33, §4552(a)(2)(A), substituted ''1995, 1996, and 1997'' for ''each subsequent year''.

Subsec. (a)(9)(B)(v), (vi). Pub. L. 105–33, §4552(a)(1), (2)(B), (3), added cls. (v) and (vi).

Subsec. (a)(9)(D). Pub. L. 105–33, §4552(b), as amended by Pub. L. 116–260, §121(b)(1), added subpar. (D).

Subsec. (a)(10)(B). Pub. L. 105–33, §4316(b), substituted ''The Secretary'' for ''For covered items furnished on or after January 1, 1991, the Secretary'' and struck out ''(other than subparagraph (D))'' before ''of section 1395u(b) of this title'' and ''as such provisions would otherwise apply to physicians' services and physicians and a reasonable charge under section 1395u(b) of this title but for the application of section 1395w–4(i)(3) of this title. In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item

is furnished) that such payment basis is not inherently reasonable'' before period at end.

Subsec. (a)(14)(B). Pub. L. 105–33, §4551(a)(1)(B)(i), substituted ''1993, 1994, 1995, 1996, and 1997'' for ''a subsequent year''.

Subsec. (a)(14)(C), (D). Pub. L. 105–33, §4551(a)(1)(A), (B)(ii), (C), added subpars. (C) and (D).

Subsec. (a)(16). Pub. L. 105–33, §4312(c), inserted at end ''The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1395u(b)(18)(C) of this title) who furnish items or services under this part.''

Pub. L. 105–33, §4312(a), added par. (16).

Subsec. (a)(17). Pub. L. 105–33, §4551(c)(1), added par. (17) relating to certain upgraded items.

Subsec. (c)(1)(C). Pub. L. 105–33, §4101(c), in introductory provisions, struck out '', subject to the deductible established under section 1395*l*(b) of this title,'' before ''be equal to 80''.

Subsec. (c)(2)(A)(iii). Pub. L. 105–33, §4101(a)(1), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: ''In the case of a woman over 39 years of age, but under 50 years of age, who—

''(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

''(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.''

Subsec. (c)(2)(A)(iv), (v). Pub. L. 105–33, §4101(a)(2), struck out cls. (iv) and (v), which read as follows:

''(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

''(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.''

Subsec. (d). Pub. L. 105–33, §4104(b)(1), added subsec. (d).

Subsec. (g). Pub. L. 105–33, §4201(c)(5), amended heading and text of subsec. (g) generally. Prior to amendment, text related to payment for outpatient rural primary care hospital services as determined, in par. (1), by either the cost-based facility fee plus professional charges method or the all-inclusive rate method and, in par. (2), by the prospective payment system.

Subsec. (h)(4)(A)(iv). Pub. L. 105–33, §4551(a)(2)(B), substituted ''1996 and 1997'' for ''a subsequent year''.

Subsec. (h)(4)(A)(v), (vi). Pub. L. 105–33, §4551(a)(2)(A), (C), added cls. (v) and (vi).

Subsec. (k). Pub. L. 105–33, §4541(a)(2), added subsec. (k).

Subsec. (*l*). Pub. L. 105–33, §4531(b)(2), added subsec. (*l*).

1994—Subsec. (a)(3)(D). Pub. L. 103–432, §135(e)(5), struck out heading and text of subpar. (D). Text read as follows: ''If the reasonable useful lifetime of such an item, as established under paragraph (7)(C), has been reached during a continuous period of medical need, or the Secretary determines on the basis of investigation by the carrier that the item is lost or irreparably damaged, payment for an item serving as a replacement for such item shall be made on a monthly basis for the rental of the replacement item in accordance with subparagraph (A).''

Subsec. (a)(5)(E). Pub. L. 103–432, §135(d)(1), substituted ''pressure of 56'' for ''pressure of 55''.

Subsec. (a)(7). Pub. L. 103–432, §135(e)(2), made technical amendment to directory language of Pub. L. 101–508, §4152(c)(2). See 1990 Amendment note below.

Subsec. (a)(7)(A)(iii)(II). Pub. L. 103–432, §135(e)(3), substituted ''clause (vi)'' for ''clause (v)''.

Subsec. (a)(7)(C)(i). Pub. L. 103–432, §135(e)(4), substituted ''this paragraph'' for ''this paragraph or paragraph (3)''.

Subsec. (a)(10)(B). Pub. L. 103–432, §134(a)(1), inserted at end ''In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.''

Pub. L. 103–432, §126(g)(10)(B), substituted ''would otherwise apply to physicians' services'' for ''apply to physicians' services'' and inserted before period at end ''but for the application of section 1395w–4(i)(3) of this title''.

Subsec. (a)(14)(A). Pub. L. 103–432, §135(a)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''for 1991 and 1992, reduction of 1 percentage point; and''.

Subsec. (a)(15). Pub. L. 103–432, §135(b)(1), amended heading and text of par. (15) generally. Prior to amendment, text read as follows:

''(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters.

''(B) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance whether payment for an item included on the list developed by the Secretary under subparagraph (A) may not be made because of the application of section 1395y(a)(1) of this title.''

Subsec. (a)(16). Pub. L. 103–432, §131(a)(2), struck out heading and text of par. (16). Text read as follows:

''(A) IN GENERAL.—A supplier of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

''(B) PENALTY.—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed $1,000 for each such form or document so distributed. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (a)(17), (18). Pub. L. 103–432, §132(a)(1), (2), added pars. (17) and (18).

Subsec. (b)(4)(D). Pub. L. 103–432, §126(b)(2)(A), in introductory provisions substituted ''shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:'' for ''shall be determined as follows:''.

Subsec. (b)(4)(D)(iv). Pub. L. 103–432, §126(b)(2)(B), substituted ''Adjusted conversion factor'' for ''Local adjustment'' in heading and ''The adjusted conversion factor for'' for ''Subject to clause (vii), the conversion factor to be applied to'' in text.

Subsec. (b)(4)(D)(vii). Pub. L. 103–432, §126(b)(2)(C), (D), struck out ''under this subparagraph'' after ''applied to a locality'' and inserted ''reduced under this subparagraph by'' before ''more than 9.5 percent''.

Subsec. (b)(4)(E). Pub. L. 103–432, §126(b)(5), inserted heading ''Rule for certain scanning services''.

Pub. L. 103–432, §126(b)(4), made technical amendment to directory language of Pub. L. 101–508, §4102(d). See 1990 Amendment note below.

Pub. L. 103–432, §126(b)(1), redesignated subpar. (E), relating to subsequent updating, as (F).

Subsec. (b)(4)(F), (G). Pub. L. 103–432, §126(b)(1), redesignated subpars. (E), relating to subsequent updating, and (F) as (F) and (G), respectively.

Subsec. (c)(1)(B). Pub. L. 103–432, §145(a)(1), substituted ''is conducted by a facility that has a certificate (or provisional certificate) issued under section 263b of this title'' for ''meets the quality standards established under paragraph (3)''.

Subsec. (c)(1)(C)(iii). Pub. L. 103–432, §145(a)(2), substituted ''paragraph (3)'' for ''paragraph (4)''.

Subsec. (c)(3) to (5). Pub. L. 103–432, §145(a)(3), (4), redesignated pars. (4) and (5) as (3) and (4), respectively, and struck out former par. (3) which directed Secretary to establish standards to assure the safety and accuracy of screening mammography performed under this part.

Subsec. (f). Pub. L. 103–432, §126(g)(1), substituted ''during 1991'' for ''during fiscal year 1991'' in heading.

Subsec. (g)(1). Pub. L. 103–432, §102(e)(1)(A), (2), substituted in introductory provisions ''during a year before the prospective payment system described in paragraph (2) is in effect'' for ''during a year before 1993'' and inserted at end ''The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.''

Subsec. (g)(1)(B). Pub. L. 103–432, §156(a)(2)(C), struck out ''and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion'' after ''section 1395x(s)(10)(A) of this title''.

Subsec. (g)(2). Pub. L. 103–432, §102(e)(1)(B), substituted ''January 1, 1996'' for ''January 1, 1993''.

Subsec. (h)(3). Pub. L. 103–432, §135(b)(3), substituted ''Paragraphs (12), (15), and (17)'' for ''Paragraphs (12) and (17)''.

Pub. L. 103–432, §132(b), substituted ''Paragraphs (12) and (17)'' for ''Paragraph (12)''.

Subsec. (j). Pub. L. 103–432, §131(a)(1), added subsec. (j).

Subsec. (j)(4), (5). Pub. L. 103–432, §133(a)(1), added par. (4) and redesignated former par. (4) as (5).

1993—Subsec. (a)(1)(D). Pub. L. 103–66, §13545(a), substituted ''45 percent'' for ''15 percent'' after ''(as previously reduced) by''.

Subsec. (a)(2)(A)(iii). Pub. L. 103–66, §13543(b), added cl. (iii).

Subsec. (a)(2)(C). Pub. L. 103–66, §13542(a)(1), in cl. (i)(II), substituted ''for 1992, 1993, and 1994'' for ''for 1992'' and ''update for the year'' for ''update for 1992'', and in cl. (ii), struck out ''and'' at end of subcl. (I), added subcls. (II) and (III), and redesignated former subcl. (II) as (IV).

Subsec. (a)(3)(A). Pub. L. 103–66, §13543(a), substituted ''IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices'' for ''ventilators, aspirators, IPPB machines, and nebulizers''.

Subsec. (a)(3)(C). Pub. L. 103–66, §13542(a)(1), in cl. (i)(II), substituted ''for 1992, 1993, and 1994'' for ''for 1992'' and ''update for the year'' for ''update for 1992'', and in cl. (ii), struck out ''and'' at end of subcl. (I), added subcls. (II) and (III), and redesignated former subcl. (II) as (IV).

Subsec. (a)(8)(A)(ii)(III). Pub. L. 103–66, §13542(a)(2)(A), substituted ''1992, 1993, and 1994'' for ''1992''.

Subsec. (a)(8)(B)(ii) to (iv). Pub. L. 103–66, §13542(a)(2)(B), added cls. (ii) and (iii) and redesignated former cl. (ii) as (iv).

Subsec. (a)(9)(A)(ii)(II). Pub. L. 103–66, §13542(a)(3)(A), substituted ''1991, 1992, 1993, and 1994'' for ''1991 and 1992''.

Subsec. (a)(9)(B)(ii) to (iv). Pub. L. 103–66, §13542(a)(3)(B), added cls. (ii) and (iii) and redesignated former cl. (ii) as (iv).

Subsec. (h)(1)(B). Pub. L. 103–66, §13544(a)(2), substituted ''subparagraphs (C) and (E)'' for ''subparagraph (C)'' in introductory provisions.

Subsec. (h)(1)(E). Pub. L. 103–66, §13544(a)(1), added subpar. (E).

Subsec. (h)(4)(A). Pub. L. 103–66, §13546, struck out ''and'' at end of cl. (i), substituted ''1992 and 1993'' for ''a subsequent year'' in cl. (ii), and added cls. (iii) and (iv).

Subsec. (i). Pub. L. 103–66, §13544(b)(1), added subsec. (i).

1990—Subsec. (a). Pub. L. 101–508, §4153(a)(2)(D)(i), struck out '', prosthetic devices, orthotics, and prosthetics'' after ''medical equipment'' in heading.

Subsec. (a)(1)(D). Pub. L. 101–508, §4152(a)(1), inserted before period at end '', and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent''.

Subsec. (a)(2)(A). Pub. L. 101–508, §4153(a)(2)(D)(ii), substituted ''(13)'' for ''(13)(A)''.

Pub. L. 101–508, §4152(c)(4)(A), inserted ''or'' after ''$150,'' in cl. (i), struck out ''or'' after ''purchase,'' in cl. (ii), and struck out cl. (iii) which read as follows: ''which is a power-driven wheelchair (other than a customized wheelchair that is classified as a customized item under paragraph (4) pursuant to criteria specified by the Secretary),''.

Subsec. (a)(2)(B). Pub. L. 101–508, §4152(b)(1)(A), (B), struck out ''or'' after ''1987;'' in cl. (i), added cls. (ii) to (iv), and struck out former cl. (ii) which read as follows: ''in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year.''

Subsec. (a)(2)(C). Pub. L. 101–508, §4152(b)(1)(C), added subpar. (C).

Subsec. (a)(3)(B). Pub. L. 101–508, §4152(b)(1)(A), (B), struck out ''or'' after ''1987;'' in cl. (i), added cls. (ii) to (iv), and struck out former cl. (ii) which read as follows: ''in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year.''

Subsec. (a)(3)(C). Pub. L. 101–508, §4152(b)(1)(C), added subpar. (C).

Subsec. (a)(3)(D). Pub. L. 101–508, §4152(c)(3), added subpar. (D).

Subsec. (a)(4). Pub. L. 101–508, §4152(c)(4)(B)(i), directed amendment of par. (4) by inserting at end ''In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.'' The amendment did not become effective pursuant to Pub. L. 101–508, §4152(c)(4)(B)(ii). See Effective Date of 1990 Amendment note below.

Subsec. (a)(5)(A). Pub. L. 101–508, §4152(g)(1)(A), substituted ''(B), (C), and (E)'' for ''(B) and (C)''.

Subsec. (a)(5)(E). Pub. L. 101–508, §4152(g)(1)(B), added subpar. (E).

Subsec. (a)(7)(A)(i). Pub. L. 101–508, §4152(c)(2)(A), as amended by Pub. L. 103–432, §135(e)(2), substituted ''15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months'' for ''15 months''.

Pub. L. 101–508, §4152(c)(1), substituted ''for each of the first 3 months of such period'' for ''for each such month'' and '', and for each of the remaining months of such period is 7.5 percent of such purchase price;'' for semicolon at end.

Subsec. (a)(7)(A)(ii), (iii). Pub. L. 101–508, § 4152(c)(2)(D), as amended by Pub. L. 103–432, § 135(e)(2), added cls. (ii) and (iii). Former cls. (ii) and (iii) redesignated (iv) and (v), respectively.

Subsec. (a)(7)(A)(iv). Pub. L. 101–508, § 4152(c)(2)(B), as amended by Pub. L. 103–432, § 135(e)(2), redesignated cl. (ii) as (iv), substituted ''in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i),'' for ''during the succeeding 6-month period of medical need,'' and struck out ''and'' at end.

Subsec. (a)(7)(A)(v). Pub. L. 101–508, § 4152(c)(2)(C), as amended by Pub. L. 103–432, § 135(e)(2), redesignated cl. (iii) as (v), inserted at beginning ''in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii),'', and substituted ''; and'' for period at end.

Subsec. (a)(7)(A)(vi). Pub. L. 101–508, § 4152(c)(2)(E), as amended by Pub. L. 103–432, § 135(e)(2), added cl. (vi).

Subsec. (a)(7)(C). Pub. L. 101–508, § 4152(c)(2)(F), as amended by Pub. L. 103–432, § 135(e)(2), added subpar. (C).

Subsec. (a)(8)(A)(ii). Pub. L. 101–508, § 4152(b)(2)(A), added subcl. (II), redesignated former subcl. (II) as (III), struck out ''1991 or'' before ''1992'', and substituted ''the covered item update for the year'' for ''the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year''.

Subsec. (a)(8)(B). Pub. L. 101–508, § 4152(b)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

''(i) for 1991 and for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

''(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.''

Subsec. (a)(8)(C). Pub. L. 101–508, § 4152(b)(2)(C)(ii), struck out ''and subject to subparagraph (D)'' after ''and (7)'' in introductory provisions.

Subsec. (a)(8)(C)(ii). Pub. L. 101–508, § 4152(b)(2)(C)(i), (iii), in subcl. (I) substituted ''67 percent'' for ''75 percent'' and in subcl. (II) substituted ''33 percent'' for ''25 percent'' and ''national limited purchase price'' for ''regional purchase price''.

Subsec. (a)(8)(C)(iii). Pub. L. 101–508, § 4152(b)(2)(C)(i), (iv), in subcl. (I) substituted ''33 percent'' for ''50 percent'' and ''subparagraph (A)(ii)(III)'' for ''subparagraph (A)(ii)(II)'' and in subcl. (II) substituted ''67 percent'' for ''50 percent'' and ''national limited purchase price'' for ''regional purchase price''.

Subsec. (a)(8)(C)(iv). Pub. L. 101–508, § 4152(b)(2)(C)(i), substituted ''national limited purchase price'' for ''regional purchase price''.

Subsec. (a)(8)(D). Pub. L. 101–508, § 4152(b)(2)(D), struck out subpar. (D) which read as follows: ''The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

''(i) in 1991, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

''(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.''

Subsec. (a)(9)(A)(ii)(II). Pub. L. 101–508, § 4152(b)(3)(A), substituted ''the covered item increase for the year'' for ''the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year''.

Subsec. (a)(9)(B). Pub. L. 101–508, § 4152(b)(3)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''With respect to the furnishing of an item in each region (as defined by the Secretary), the Secretary shall compute a regional monthly payment rate—

''(i) for 1991 and 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local monthly payment rates for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

''(ii) for each subsequent year, equal to the regional monthly payment rates computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.''

Subsec. (a)(9)(C)(ii). Pub. L. 101–508, § 4152(b)(3)(C)(i), (ii), in subcl. (I) substituted ''67 percent'' for ''75 percent'' and in subcl. (II) substituted ''33 percent'' for ''25 percent'' and ''national limited monthly payment rate'' for ''regional monthly payment rate''.

Subsec. (a)(9)(C)(iii). Pub. L. 101–508, § 4152(b)(3)(C)(i), (iii), in subcl. (I) substituted ''33 percent'' for ''50 percent'' and in subcl. (II) substituted ''67 percent'' for ''50 percent'', ''national limited monthly payment rate'' for ''regional monthly payment rate'', and ''subparagraph (B)(ii)'' for ''subparagraph (B)(i)''.

Subsec. (a)(9)(C)(iv). Pub. L. 101–508, § 4152(b)(3)(C)(i), substituted ''national limited monthly payment rate'' for ''regional monthly payment rate''.

Subsec. (a)(9)(D). Pub. L. 101–508, § 4152(b)(3)(D), struck out subpar. (D) which read as follows: ''The amount that is recognized under subparagraph (C) as the base monthly payment amount for an item furnished—

''(i) in 1991, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year; and

''(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year.''

Subsec. (a)(12). Pub. L. 101–508, § 4152(b)(5), struck out ''defined for purposes of paragraphs (8)(B) and (9)(B)'' after ''one or more entire regions''.

Subsec. (a)(13). Pub. L. 101–508, § 4153(a)(2)(D)(iii), substituted ''means durable medical equipment (as defined in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title).'' for ''means—

''(A) durable medical equipment (as defined in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title;

''(B) prosthetic devices (described in section 1395x(s)(8) of this title), but not including parenteral and enteral nutrition nutrients, supplies, and equipment; and

''(C) orthotics and prosthetics (described in section 1395x(s)(9) of this title);

but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title.''

Subsec. (a)(14). Pub. L. 101–508, § 4152(b)(4), added par. (14).

Subsec. (a)(15). Pub. L. 101–508, § 4152(e), added par. (15).

Subsec. (a)(16). Pub. L. 101–508, § 4152(f)(1), added par. (16).

Subsec. (b)(1)(B). Pub. L. 101–508, § 4163(b)(1), inserted ''and subject to subsection (c)(1)(A)'' after ''conversion factors''.

Pub. L. 101–508, §4102(f), inserted ''locality,'' after ''statewide,''.

Subsec. (b)(4)(D). Pub. L. 101–508, §4102(a)(2), added subpar. (D). Former subpar. (D) redesignated (E) relating to subsequent updating.

Subsec. (b)(4)(E). Pub. L. 101–508, §4102(d), as amended by Pub. L. 103–432, §126(b)(4), added subpar. (E) relating to rule for certain scanning services.

Pub. L. 101–508, §4102(a)(1), redesignated subpar. (D), relating to subsequent updating, as (E). Former subpar. (E) redesignated (F).

Subsec. (b)(4)(F). Pub. L. 101–508, §4102(a)(1), redesignated subpar. (E) as (F).

Subsec. (c). Pub. L. 101–508, §4163(b)(2), added subsec. (c).

Subsec. (f). Pub. L. 101–508, §4104(a), amended subsec. (f) generally, substituting provisions relating to reduction in payments for physician pathology services during 1991 for provisions directing Secretary to provide for application of a fee schedule with respect to such services.

Subsec. (h). Pub. L. 101–508, §4153(a)(1), added subsec. (h).

1989—Subsec. (a)(1)(D). Pub. L. 101–239, §6112(c), added subpar. (D).

Subsec. (a)(2)(A)(iii). Pub. L. 101–239, §6112(d)(1), added cl. (iii).

Subsec. (a)(2)(B)(i), (3)(B)(i). Pub. L. 101–239, §6112(a)(1), inserted ''and in 1990'' after ''1989''.

Subsec. (a)(7)(A)(i). Pub. L. 101–239, §6112(a)(4)(A), substituted ''this clause'' for ''this subparagraph''.

Subsec. (a)(7)(B)(i). Pub. L. 101–239, §6112(a)(4)(B), inserted ''in'' after ''rental of the item''.

Subsec. (a)(7)(B)(ii). Pub. L. 101–239, §6112(a)(4)(C), substituted ''clause (i) shall apply in the same manner as it applies to items furnished during 1989'' for ''the payment amount recognized under subparagraph (A)(i) shall not be more than the maximum amount established under clause (i), and shall not be less than the minimum amount established under such clause, for 1989, each such amount increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 1989''.

Subsec. (a)(8)(A)(ii)(I). Pub. L. 101–239, §6112(a)(2)(A), inserted ''and 1990'' after ''1989''.

Subsec. (a)(8)(A)(ii)(II). Pub. L. 101–239, §6112(a)(2)(B), substituted ''1991 or 1992'' for ''1990, 1991, or 1992''.

Subsec. (a)(8)(D)(i). Pub. L. 101–239, §6140(1), substituted ''1991, may not exceed 125 percent, and may not be lower than 85 percent'' for ''1991, may not exceed 130 percent, and may not be lower than 80 percent''.

Subsec. (a)(8)(D)(ii). Pub. L. 101–239, §6140(2), substituted ''120 percent, and may not be lower than 90 percent'' for ''125 percent, and may not be lower than 85 percent''.

Subsec. (a)(9)(A)(ii)(I). Pub. L. 101–239, §6112(a)(3)(A), inserted ''and 1990'' after ''1989''.

Subsec. (a)(9)(A)(ii)(II). Pub. L. 101–239, §6112(a)(3)(B), substituted ''1991 and 1992'' for ''1990, 1991, and 1992''.

Subsec. (a)(9)(D)(i). Pub. L. 101–239, §6140(1), substituted ''1991, may not exceed 125 percent, and may not be lower than 85 percent'' for ''1991, may not exceed 130 percent, and may not be lower than 80 percent''.

Subsec. (a)(9)(D)(ii). Pub. L. 101–239, §6140(2), substituted ''120 percent, and may not be lower than 90 percent'' for ''125 percent, and may not be lower than 85 percent''.

Subsec. (a)(13). Pub. L. 101–239, §6112(e)(2), inserted before period at end ''or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title''.

Subsec. (b)(1)(B). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §204(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(4)(A). Pub. L. 101–234, §301(b)(1), (c)(1), amended subpar. (A) identically, substituting ''coinsurance and deductibles under sections 1395*l*(a)(1)(J)'' for ''insurance and deductibles under section 1395n(a)(1)(I)''.

Subsec. (b)(4)(C) to (E). Pub. L. 101–239, §6105(a), added subpar. (C) and redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsecs. (c) to (e). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§202(b)(4), 203(c)(1)(F), 204(b)(2), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (f). Pub. L. 101–239, §6102(f)(1), added subsec. (f).

Subsec. (g). Pub. L. 101–239, §6116(b)(2), added subsec. (g).

1988—Pub. L. 100–360, §411(g)(1)(A), inserted ''items and'' in section catchline.

Subsec. (a)(1)(C). Pub. L. 100–360, §411(g)(1)(B)(i), inserted ''or under part A to a home health agency'' before period at end.

Subsec. (a)(2)(A). Pub. L. 100–360, §411(g)(1)(B)(iii), struck out ''rental'' before ''payments'' in concluding provisions.

Subsec. (a)(2)(B)(i). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted ''reasonable'' for ''allowed''.

Subsec. (a)(3)(A). Pub. L. 100–360, §411(g)(1)(B)(iv), struck out the extra space appearing in text of original act after ''ventilators''.

Subsec. (a)(3)(B)(i). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted ''reasonable'' for ''allowable''.

Subsec. (a)(4). Pub. L. 100–360, §411(g)(1) (B)(v)–(vii), inserted '', and for that reason cannot be grouped with similar items for purposes of payment under this subchapter,'' after ''individual patient'', inserted cl. (A) and (B) designations, and in cl. (B), substituted ''servicing'' for ''service'' in two places.

Subsec. (a)(7)(A)(ii). Pub. L. 100–360, §411(g)(1) (B)(vii), inserted ''maintenance and'' before ''servicing''.

Subsec. (a)(7)(A)(iii). Pub. L. 100–360, §411(g)(1) (B)(vii), (viii), substituted ''maintenance and servicing'' for ''service and maintenance'', and in subcl. (I) substituted ''fee or fees established by the Secretary'' for ''fee established by the carrier''.

Subsec. (a)(7)(B)(i). Pub. L. 100–360, §411(a)(3)(A), (C)(ii), provided that subsec. (a)(7)(B)(i) of this section, as inserted by section 4062(b) of Pub. L. 100–203, is deemed to have a reference to ''1987'' immediately after ''December''.

Subsec. (a)(8)(A)(i)(I). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted ''reasonable'' for ''allowable''.

Subsec. (a)(8)(B). Pub. L. 100–360, §411(g)(1)(B)(xi), as amended Pub. L. 100–485, §608(d)(22)(A)(i), substituted ''(as defined by the Secretary)'' for ''(as defined in section 1395ww(d)(2)(D) of this title)'', and in cl. (i) struck out the comma after ''1991''.

Subsec. (a)(9)(A)(ii)(I). Pub. L. 100–360, §411(g)(1) (B)(ix), substituted ''6-month'' for ''12-month''.

Subsec. (a)(9)(A)(ii)(II). Pub. L. 100–360, §411(g)(1) (B)(x), substituted '', 1991, and 1992'' for ''and to 1991''.

Subsec. (a)(9)(B). Pub. L. 100–360, §411(g)(1)(B)(xi), as amended by Pub. L. 100–485, §608(d)(22)(A)(i), substituted ''(as defined by the Secretary)'' for ''(as defined in section 1395ww(d)(2)(D) of this title)'', and in cl. (i) struck out the comma after ''1991''.

Subsec. (a)(9)(C)(i). Pub. L. 100–360, §411(g)(1) (B)(xii), substituted ''subparagraph (A)(ii)'' for ''subparagraph (A)(ii)(I)''.

Subsec. (a)(10)(B). Pub. L. 100–360, §411(g)(1) (B)(xiii), inserted before period at end ''and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1395u(b) of this title''.

Subsec. (a)(11)(A). Pub. L. 100–360, §411(g)(1) (B)(vii), (xiv), inserted ''maintenance and'' before ''servicing'' and substituted ''section 1395u(j)(2) of this title'' for ''subsection (j)(2) of this section''.

Subsec. (a)(12). Pub. L. 100–360, §411(g)(1)(B)(xv), as amended by Pub. L. 100–485, §608(d)(22)(A)(ii), substituted ''one or more entire regions defined for pur-

poses of paragraphs (8)(B) and (9)(B)'' for ''each region (as defined in section 1395ww(d)(2)(D) of this title)''.

Subsec. (a)(14). Pub. L. 100–360, §411(g)(1)(B)(xvi), struck out par. (14) which read as follows: ''In this subsection, any reference to the term 'carrier' includes a reference, with respect to durable medical equipment furnished by a home health agency as part of home health services, to a fiscal intermediary.''

Subsec. (b). Pub. L. 100–360, §411(a)(3)(A), (B)(ii), (f)(8)(B)(ii), amended Pub. L. 100–203, §4049(a)(2), see 1987 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 100–360, §204(b)(1), inserted ''and subject to subsection (e)(1)(A) of this section'' after ''conversion factors''.

Subsec. (b)(4)(C). Pub. L. 100–360, §411(f)(8)(D)(ii), as added by Pub. L. 100–485, §608(d)(21)(C), substituted ''For radiologist'' for ''Radiologist'' and ''1395u(i)(3) of this title'' for ''1395u(b)(4)(E)(ii) of this title''.

Subsec. (b)(4)(D), (5). Pub. L. 100–360, §411(f)(8)(D)(i), inserted ''and suppliers'' after ''physicians'' in heading.

Subsec. (b)(5)(C). Pub. L. 100–360, §411(f)(8)(D)(iii), (iv), formerly (ii), (iii), as redesignated by Pub. L. 100–485, §608(d)(21)(C), substituted ''bills'' for ''imposes a charge'' and inserted ''in the same manner as such sanctions may apply to a physician'' before period at end.

Subsec. (b)(6). Pub. L. 100–360, §411(f)(8)(D)(v), formerly (iv), as redesignated by Pub. L. 100–485, §608(d)(21)(C), substituted ''and section 1395*l*(a)(1)(J) of this title'' for '', section 1395*l*(a)(1)(I) of this title, and section 1395u(h)(1)(B) of this title''.

Pub. L. 100–360, §411(f)(8)(A), substituted ''radiology'' for ''radiologic''.

Subsec. (b)(6)(B). Pub. L. 100–360, §411(f)(8)(D)(vi), formerly (v), as redesignated by Pub. L. 100–485, §608(d)(21)(C), substituted ''the total amount of charges'' for ''billings''.

Pub. L. 100–360, §411(f)(8)(A), substituted ''radiology'' for ''radiologic''.

Subsec. (c). Pub. L. 100–360, §202(b)(4), added subsec. (c) relating to payment for covered outpatient drugs.

Subsec. (d). Pub. L. 100–360, §203(c)(1)(F), added subsec. (d) relating to home intravenous drug therapy services.

Subsec. (e). Pub. L. 100–360, §204(b)(2), added subsec. (e) relating to payments and standards for screening mammography.

1987—Subsec. (b). Pub. L. 100–203, §4049(a)(2), as amended by Pub. L. 100–360, §411(a)(3)(A), (B)(ii), (f)(8)(B)(ii), added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §121(b)(2), Dec. 27, 2020, 134 Stat. 2955, provided that: ''The amendment made by paragraph (1) [amending Pub. L. 105–33 which amended this section] shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33).''

Amendment by section 125(a)(2)(B), (c) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 5012(b) of Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2021, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable to items furnished on or after Jan. 1, 2017, see section 504(d) of Pub. L. 114–113, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3128(b), Mar. 23, 2010, 124 Stat. 426, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).''

Pub. L. 111–148, title III, §3136(c), Mar. 23, 2010, 124 Stat. 438, provided that:

''(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

''(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.''

Amendment by section 6405(a) of Pub. L. 111–148 applicable to written orders and certifications made on or after July 1, 2010, see section 6405(d) of Pub. L. 111–148, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(5) of Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110–275, title I, §144(b)(2), July 15, 2008, 122 Stat. 2547, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 2009.''

Pub. L. 110–275, title I, §146(b)(2)(B), July 15, 2008, 122 Stat. 2548, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 15, 2008].''

Pub. L. 110–275, title I, §148(b), July 15, 2008, 122 Stat. 2549, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2009.''

Pub. L. 110–275, title I, §149(c), July 15, 2008, 122 Stat. 2549, provided that: ''The amendments made by this section [amending this section and section 1395yy of this title] shall apply to services furnished on or after January 1, 2009.''

Pub. L. 110–275, title I, §154(e), July 15, 2008, 122 Stat. 2568, provided that: ''The amendments made by this section [amending this section, sections 1395u and 1395w–3 of this title, and provisions set out as notes under section 1395w–3 of this title] shall take effect as of June 30, 2008.''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title V, §5101(a)(2), Feb. 8, 2006, 120 Stat. 38, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to items furnished for which the first rental month occurs on or after January 1, 2006.''

Pub. L. 109–171, title V, §5101(b)(2), Feb. 8, 2006, 120 Stat. 39, provided that:

''(A) IN GENERAL.—The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 2006.

''(B) APPLICATION TO CERTAIN INDIVIDUALS.—In the case of an individual receiving oxygen equipment on December 31, 2005, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 36-month period described in paragraph (5)(F)(i) of such section, as added by paragraph (1), shall begin on January 1, 2006.''

Amendment by section 5113(b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5113(c) of Pub. L. 109–171, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 405(a)(1) of Pub. L. 108–173 applicable to payments for services furnished during cost reporting periods beginning on or after Jan. 1, 2004, see section 405(a)(2) of Pub. L. 108–173, set out as a note under section 1395f of this title.

Pub. L. 108–173, title IV, §405(b)(2), Dec. 8, 2003, 117 Stat. 2266, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply with respect to costs incurred for services furnished on or after January 1, 2005.''

Pub. L. 108–173, title IV, §405(d)(2), Dec. 8, 2003, 117 Stat. 2267, provided that:

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 2004.

''(B) RULE OF APPLICATION.—In the case of a critical access hospital that made an election under section 1834(g)(2) of the Social Security Act (42 U.S.C. 1395m(g)(2)) before November 1, 2003, the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2001.''

Pub. L. 108–173, title IV, §415(c), Dec. 8, 2003, 117 Stat. 2282, provided that: ''The amendments made by this subsection [probably should be ''this section'', amending this section and section 1395x of this title] shall apply to services furnished on or after January 1, 2005.''

Amendment by section 627(b)(1) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2005, see section 627(c) of Pub. L. 108–173, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §103(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–469, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to colorectal cancer screening services provided on or after July 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title I, §104(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–470, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1395w–4 of this title] shall apply with respect to screening mammographies furnished on or after January 1, 2002.''

Amendment by section 1(a)(6) [title II, §201(a)] of Pub. L. 106–554 applicable to services furnished on or after Nov. 29, 1999, see section 1(a)(6) [title II, §201(c)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title II, §202(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after July 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title II, §204(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 2001.''

Amendment by section 1(a)(6) [title II, §205(a)] of Pub. L. 106–554 applicable to services furnished on or after Dec. 21, 2000, see section 1(a)(6) [title II, §205(c)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title II, §221(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2001. In applying such amendment to services furnished on or after such date and before January 1, 2002, the amount of the rate increase provided under such amendment shall be equal to $1.25 per mile.''

Amendment by section 1(a)(6) [title II, §223(b)] of Pub. L. 106–554 effective for services furnished on or after Oct. 1, 2001, see section 1(a)(6) [title II, §223(e)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title IV, §423(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after July 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title IV, §428(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to items replaced on or after April 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title II, §201(e)(2)] of Pub. L. 106–113 effective as if included in enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see §1000(a)(6) [title II, §201(m)] of Pub. L. 106–113, set out as a note under section 1395*l* of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(3)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(d)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, as amended by Pub. L. 106–554, §1(a)(6) [title II, §201(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: ''Paragraphs (1) through (3) of section 1834(g) of the Social Security Act [42 U.S.C. 1395m(g)(1)–(3)] (as amended by paragraph (1)) apply for cost reporting periods beginning on or after October 1, 2000.''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4101(a), (c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4101(d) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4104(b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Pub. L. 105–33, title IV, §4105(d), Aug. 5, 1997, 111 Stat. 367, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1395w–4 and 1395x of this title] shall apply to items and services furnished on or after July 1, 1998.

''(2) TESTING STRIPS.—The amendment made by subsection (b)(2) [amending this section] shall apply with respect to blood glucose testing strips furnished on or after January 1, 1998.''

Amendment by section 4201(c)(5) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4312(f)(1), Aug. 5, 1997, 111 Stat. 387, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4312(f)(3), Aug. 5, 1997, 111 Stat. 388, provided that: ''The amendments made by subsections (c) through (e) [amending this section and section 1395x of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and may be applied with respect to items and services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4316(c), Aug. 5, 1997, 111 Stat. 392, provided that: ''The amendments made by this section [amending this section and section 1395u of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].''

Amendment by section 4531(b)(2) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 2000, see section 4531(b)(3) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4541(a)(2) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, including portions of cost reporting periods occurring

on or after such date, except that subsec. (k) of this section inapplicable to services described in section 1395*l*(a)(8)(B) of this title that are furnished during 1998, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Pub. L. 105–33, title IV, § 4551(c)(2), Aug. 5, 1997, 111 Stat. 459, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to purchases or rentals after the effective date of any regulations issued pursuant to such amendment.''

Pub. L. 105–33, title IV, § 4552(e), Aug. 5, 1997, 111 Stat. 459, provided that:

''(1) OXYGEN.—The amendments made by subsection (a) [amending this section] shall apply to items furnished on and after January 1, 1998.

''(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 126(i), Oct. 31, 1994, 108 Stat. 4416, provided that: ''Except as provided in subsection (h) [amending section 1395u of this title, enacting provisions set out as notes under sections 1395u and 1395w–4 of this title, and amending provisions set out as a note under section 1395w–4 of this title], the amendments made by this section and the provisions of this section [amending this section and sections 1395u, 1395w–1, and 1395w–4 of this title, enacting provisions set out as notes under sections 1395u and 1395w–4 of this title, and amending provisions set out as notes under this section and sections 1395u and 1395w–4 of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

Pub. L. 103–432, title I, § 131(a)(2), Oct. 31, 1994, 108 Stat. 4419, provided that the amendment made by that section is effective 60 days after Oct. 31, 1994.

Pub. L. 103–432, title I, § 132(c), Oct. 31, 1994, 108 Stat. 4421, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall apply to items furnished after the expiration of the 60-day period that begins on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, § 133(c), Oct. 31, 1994, 108 Stat. 4422, provided that: ''The amendments made by this section [amending this section and sections 1395m and 1395pp of this title] shall apply to items or services furnished on or after January 1, 1995.''

Pub. L. 103–432, title I, § 134(a)(2), Oct. 31, 1994, 108 Stat. 4422, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, § 135(a)(2), Oct. 31, 1994, 108 Stat. 4422, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, § 135(b)(1), Oct. 31, 1994, 108 Stat. 4422, provided that the amendment made by that section is effective Oct. 31, 1994.

Pub. L. 103–432, title I, § 135(b)(3), Oct. 31, 1994, 108 Stat. 4423, provided that the amendment made by that section is effective Oct. 31, 1994.

Pub. L. 103–432, title I, § 135(d)(2), Oct. 31, 1994, 108 Stat. 4424, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, § 135(e)(8), Oct. 31, 1994, 108 Stat. 4424, provided that: ''The amendments made by this subsection [amending this section and provisions set out as notes under this section and section 1395cc of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

Pub. L. 103–432, title I, § 145(d), Oct. 31, 1994, 108 Stat. 4428, provided that: ''The amendments made by this section [amending this section and sections 1395x to 1395bb of this title] shall apply to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act [section 263b(b) of this title] apply to such mammography conducted by such facility.''

Amendment by section 156(a)(2)(C) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13542(b), Aug. 10, 1993, 107 Stat. 589, provided that: ''The amendments made by this section [amending this section] shall apply to items furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13543(c), Aug. 10, 1993, 107 Stat. 589, provided that: ''The amendments made by this section [amending this section] shall apply to items furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13544(a)(3), Aug. 10, 1993, 107 Stat. 589, provided that: ''The amendments made by this subsection [amending this section] shall apply to items furnished on or after January 1, 1994.''

Amendment by section 13544(b)(1) of Pub. L. 103–66 applicable to items furnished on or after Jan. 1, 1994, see section 13544(b)(3) of Pub. L. 103–66, set out as a note under section 1395*l* of this title.

Pub. L. 103–66, title XIII, § 13545(b), Aug. 10, 1993, 107 Stat. 590, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to items furnished on or after January 1, 1994.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4102(i), Nov. 5, 1990, 104 Stat. 1388–58, provided that:

''(1) Except as otherwise provided, the amendments made by this section [amending this section, section 1395w–4 of this title, and provisions set out as a note below] shall apply to services furnished on or after January 1, 1991.

''(2) The amendment made by subsection (f) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Amendment by section 4104(a) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4104(d) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

Pub. L. 101–508, title IV, § 4152(a)(3), Nov. 5, 1990, 104 Stat. 1388–74, as amended by Pub. L. 103–432, title I, § 135(e)(1), Oct. 31, 1994, 108 Stat. 4424, provided that: ''The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to items furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4152(c)(4)(B)(ii), Nov. 5, 1990, 104 Stat. 1388–79, provided that: ''The amendment made by clause (i) [amending this section] shall apply to items furnished on or after January 1, 1992, unless the Secretary develops specific criteria before that date for the treatment of wheelchairs as customized items for purposes of section 1834(a)(4) of the Social Security Act [subsec. (a)(4) of this section] (in which case the amendment made by such clause shall not become effective).'' [Criteria established by Secretary Nov. 1, 1991, see 56 F.R. 65995, Dec. 20, 1991, 42 CFR § 414.224.]

Pub. L. 101–508, title IV, § 4152(f)(2), Nov. 5, 1990, 104 Stat. 1388–80, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to forms and documents distributed on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4152(g)(2), Nov. 5, 1990, 104 Stat. 1388–80, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to patients who first receive home oxygen therapy services on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4152(i), Nov. 5, 1990, 104 Stat. 1388–81, provided that: ''Except as otherwise provided, the amendments made by this section [amending this section, section 1395x of this title, and provisions set out as a note under section 1395f of this title] shall apply to items furnished on or after January 1, 1991.''

Amendment by section 4153(a)(1), (2)(D) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(a)(3) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(b) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6102(f)(1) of Pub. L. 101–239 applicable to services furnished on or after Jan. 1, 1991, see section 6102(f)(3) of Pub. L. 101–239, set out as a note under section 1395*l* of this title.

Pub. L. 101–239, title VI, §6112(e)(4), Dec. 19, 1989, 103 Stat. 2216, provided that: ''The amendments made by this subsection [amending this section and sections 1395x and 1395cc of this title] shall apply with respect to items furnished on or after January 1, 1990.''

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Pub. L. 101–234, title III, §301(b)(1), (c)(1), Dec. 13, 1989, 103 Stat. 1985, provided that the amendments made by that section are effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(b)(4) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(c)(1)(F) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Pub. L. 100–360, title II, §204(e), July 1, 1988, 102 Stat. 729, which provided that the amendments made by section 204 of Pub. L. 100–360 [amending this section and sections 1395*l*, 1395x to 1395z, 1395aa, 1395bb, 1396a, and 1396n of this title] applied to screening mammography performed on or after January 1, 1990, and that subsec. (e)(5) of this section only applied until such time as the Secretary of Health and Human Services implemented the physician fee schedules based on relative value scale developed under section 1395w–1(e) of this title, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(3)(A), (B)(ii), (C)(ii), (f)(8)(A), (B)(ii), (D), (g)(1)(A) and (B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4049(b)(2), Dec. 22, 1987, 101 Stat. 1330–92, as amended by Pub. L. 101–239, title VI, §6102(e)(6)(B), Dec. 19, 1989, 103 Stat. 2188; Pub. L. 101–508, title IV, §4118(h)(2), Nov. 5, 1990, 104 Stat. 1388–70, provided that: ''The amendments made by this section [amending this section and section 1395*l* of this title] shall apply to services performed on or after April 1, 1989.''

[Pub. L. 101–508, title IV, §4118(h), Nov. 5, 1990, 104 Stat. 1388–70, provided that the amendment by that section to section 4049(b)(2) of Pub. L. 100–203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.]

EFFECTIVE DATE

Subsection (a) of this section applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, set out as an Effective Date of 1987 Amendment note under section 1395f of this title.

REGULATIONS

Pub. L. 106–554, §1(a)(6) [title IV, §427(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–521, provided that: ''Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall promulgate revised regulations to carry out the amendment made by subsection (a) [amending this section] using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.''

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3109(c), Mar. 23, 2010, 124 Stat. 420, provided that: ''Nothing in the provisions of or amendments made by this section [amending this section and enacting provisions set out as a note under this section] shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).''

Pub. L. 111–148, title IV, §4105(b), Mar. 23, 2010, 124 Stat. 559, provided that: ''Nothing in the amendment made by paragraph (1) [probably means subsec. (a), amending this section] shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111–72, §1(b), Oct. 13, 2009, 123 Stat. 2059, provided that: ''Nothing in subsection (a) [amending this section] shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).''

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §154(b)(1)(B), July 15, 2008, 122 Stat. 2565, provided that: ''Section 1834(a)(20)(F)(ii) of the Social Security Act [42 U.S.C. 1395m(a)(20)(F)(ii)], as added by subparagraph (A), shall not be construed as preventing the Secretary of Health and Human Services from implementing the first round of competition under section 1847 of such Act [42 U.S.C. 1395w–3] on a timely basis.''

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §121(c), Dec. 27, 2020, 134 Stat. 2955, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and amending Pub. L. 105–33 which amended this section] by program instruction or otherwise.''

Pub. L. 116–260, div. CC, title I, §123(b), Dec. 27, 2020, 134 Stat. 2957, provided that: ''Notwithstanding any other provision of law, the Secretary may implement the provisions of, or amendments made by, this section

[amending this section] by interim final rule, program instruction, or otherwise.''

ENCOURAGING USE OF TELECOMMUNICATIONS SYSTEMS FOR HOME HEALTH SERVICES FURNISHED DURING EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, § 3707, Mar. 27, 2020, 134 Stat. 418, provided that: ''With respect to home health services (as defined in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that are furnished during the emergency period described in section 1135(g)(1)(B) of such Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall consider ways to encourage the use of telecommunications systems, including for remote patient monitoring as described in section 409.46(e) of title 42, Code of Federal Regulations (or any successor regulations) and other communications or monitoring services, consistent with the plan of care for the individual, including by clarifying guidance and conducting outreach, as appropriate.''

REVISING PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM THROUGH DURATION OF EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, § 3712, Mar. 27, 2020, 134 Stat. 423, provided that:

''(a) RURAL AND NONCONTIGUOUS AREAS.—The Secretary of Health and Human Services shall implement section 414.210(g)(9)(iii) of title 42, Code of Federal Regulations (or any successor regulation), to apply the transition rule described in such section to all applicable items and services furnished in rural areas and noncontiguous areas (as such terms are defined for purposes of such section) as planned through December 31, 2020, and through the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), if longer.

''(b) AREAS OTHER THAN RURAL AND NONCONTIGUOUS AREAS.—With respect to items and services furnished on or after the date that is 30 days after the date of the enactment of this Act [Mar. 27, 2020], the Secretary of Health and Human Services shall apply section 414.210(g)(9)(iv) of title 42, Code of Federal Regulations (or any successor regulation), as if the reference to 'dates of service from June 1, 2018 through December 31, 2020, based on the fee schedule amount for the area is equal to 100 percent of the adjusted payment amount established under this section' were instead a reference to 'dates of service from March 6, 2020, through the remainder of the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), based on the fee schedule amount for the area is equal to 75 percent of the adjusted payment amount established under this section and 25 percent of the unadjusted fee schedule amount'.''

IMPLEMENTATION OF 2018 AMENDMENT

Pub. L. 115–271, title II, § 2001(b), Oct. 24, 2018, 132 Stat. 3925, provided that: ''The Secretary of Health and Human Services (in this section [amending this section] referred to as the 'Secretary') may implement the amendments made by this section by interim final rule.''

IMPLEMENTATION OF 2015 AMENDMENT

Pub. L. 114–10, title V, § 504(b), Apr. 16, 2015, 129 Stat. 166, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise.''

IMPLEMENTATION OF 2010 AMENDMENT

Pub. L. 111–148, title III, § 3109(b), Mar. 23, 2010, 124 Stat. 419, provided that: ''Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise.''

DEMONSTRATION PROJECT TO ASSESS THE APPROPRIATE USE OF IMAGING SERVICES

Pub. L. 110–275, title I, § 135(b), July 15, 2008, 122 Stat. 2535, provided that:

''(1) CONDUCT OF DEMONSTRATION PROJECT.—

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a demonstration project using the models described in paragraph (2)(E) to collect data regarding physician compliance with appropriateness criteria selected under paragraph (2)(D) in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

''(B) ADVANCED DIAGNOSTIC IMAGING SERVICES.—In this subsection, the term 'advanced diagnostic imaging services' has the meaning given such term in section 1834(e)(1)(B) of the Social Security Act [42 U.S.C. 1395m(e)(1)(B)], as added by subsection (a).

''(C) AUTHORITY TO FOCUS DEMONSTRATION PROJECT.—The Secretary may focus the demonstration project with respect to certain advanced diagnostic imaging services, such as services that account for a large amount of expenditures under the Medicare program, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exists.

''(2) IMPLEMENTATION AND DESIGN OF DEMONSTRATION PROJECT.—

''(A) IMPLEMENTATION AND DURATION.—

''(i) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this subsection not later than January 1, 2010.

''(ii) DURATION.—The Secretary shall conduct the demonstration project under this subsection for a 2-year period.

''(B) APPLICATION AND SELECTION OF PARTICIPATING PHYSICIANS.—

''(i) APPLICATION.—Each physician that desires to participate in the demonstration project under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(ii) SELECTION.—The Secretary shall select physicians to participate in the demonstration project under this subsection from among physicians submitting applications under clause (i). The Secretary shall ensure that the physicians selected—

''(I) represent a wide range of geographic areas, demographic characteristics (such as urban, rural, and suburban), and practice settings (such as private and academic practices); and

''(II) have the capability to submit data to the Secretary (or an entity under a subcontract with the Secretary) in an electronic format in accordance with standards established by the Secretary.

''(C) ADMINISTRATIVE COSTS AND INCENTIVES.—The Secretary shall—

''(i) reimburse physicians for reasonable administrative costs incurred in participating in the demonstration project under this subsection; and

''(ii) provide reasonable incentives to physicians to encourage participation in the demonstration project under this subsection.

''(D) USE OF APPROPRIATENESS CRITERIA.—

''(i) IN GENERAL.—The Secretary, in consultation with medical specialty societies and other stakeholders, shall select criteria with respect to the clinical appropriateness of advanced diagnostic imaging services for use in the demonstration project under this subsection.

''(ii) CRITERIA SELECTED.—Any criteria selected under clause (i) shall—

''(I) be developed or endorsed by a medical specialty society; and

''(II) be developed in adherence to appropriateness principles developed by a consensus organization, such as the AQA alliance.

''(E) MODELS FOR COLLECTING DATA REGARDING PHYSICIAN COMPLIANCE WITH SELECTED CRITERIA.—Subject to subparagraph (H), in carrying out the demonstration project under this subsection, the Secretary shall use each of the following models for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D):

''(i) A model described in subparagraph (F).

''(ii) A model described in subparagraph (G).

''(iii) Any other model that the Secretary determines to be useful in evaluating the use of appropriateness criteria for advanced diagnostic imaging services.

''(F) POINT OF SERVICE MODEL DESCRIBED.—A model described in this subparagraph is a model that—

''(i) uses an electronic or paper intake form that—

''(I) contains a certification by the physician furnishing the imaging service that the data on the intake form was confirmed with the Medicare beneficiary before the service was furnished;

''(II) contains standardized data elements for diagnosis, service ordered, service furnished, and such other information determined by the Secretary, in consultation with medical specialty societies and other stakeholders, to be germane to evaluating the effectiveness of the use of appropriateness criteria selected under subparagraph (D); and

''(III) is accessible to physicians participating in the demonstration project under this subsection in a format that allows for the electronic submission of such form; and

''(ii) provides for feedback reports in accordance with paragraph (3)(B).

''(G) POINT OF ORDER MODEL DESCRIBED.—A model described in this subparagraph is a model that—

''(i) uses a computerized order-entry system that requires the transmittal of relevant supporting information at the time of referral for advanced diagnostic imaging services and provides automated decision-support feedback to the referring physician regarding the appropriateness of furnishing such imaging services; and

''(ii) provides for feedback reports in accordance with paragraph (3)(B).

''(H) LIMITATION.—In no case may the Secretary use prior authorization—

''(i) as a model for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D) under the demonstration project under this subsection; or

''(ii) under any model used for collecting such data under the demonstration project.

''(I) REQUIRED CONTRACTS AND PERFORMANCE STANDARDS FOR CERTAIN ENTITIES.—

''(i) IN GENERAL.—The Secretary shall enter into contracts with entities to carry out the model described in subparagraph (G).

''(ii) PERFORMANCE STANDARDS.—The Secretary shall establish and enforce performance standards for such entities under the contracts entered into under clause (i), including performance standards with respect to—

''(I) the satisfaction of Medicare beneficiaries who are furnished advanced diagnostic imaging services by a physician participating in the demonstration project;

''(II) the satisfaction of physicians participating in the demonstration project;

''(III) if applicable, timelines for the provision of feedback reports under paragraph (3)(B); and

''(IV) any other areas determined appropriate by the Secretary.

''(3) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES AND FEEDBACK REPORTS.—

''(A) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES.—The Secretary shall consult with medical specialty societies and other stakeholders to develop mechanisms for comparing the utilization of advanced diagnostic imaging services by physicians participating in the demonstration project under this subsection against—

''(i) the appropriateness criteria selected under paragraph (2)(D); and

''(ii) to the extent feasible, the utilization of such services by physicians not participating in the demonstration project.

''(B) FEEDBACK REPORTS.—The Secretary shall, in consultation with medical specialty societies and other stakeholders, develop mechanisms to provide feedback reports to physicians participating in the demonstration project under this subsection. Such feedback reports shall include—

''(i) a profile of the rate of compliance by the physician with appropriateness criteria selected under paragraph (2)(D), including a comparison of—

''(I) the rate of compliance by the physician with such criteria; and

''(II) the rate of compliance by the physician's peers (as defined by the Secretary) with such criteria; and

''(ii) to the extent feasible, a comparison of—

''(I) the rate of utilization of advanced diagnostic imaging services by the physician; and

''(II) the rate of utilization of such services by the physician's peers (as defined by the Secretary) who are not participating in the demonstration project.

''(4) CONDUCT OF DEMONSTRATION PROJECT AND WAIVER.—

''(A) CONDUCT OF DEMONSTRATION PROJECT.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the demonstration project under this subsection.

''(B) WAIVER.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary to carry out the demonstration project under this subsection.

''(5) EVALUATION AND REPORT.—

''(A) EVALUATION.—The Secretary shall evaluate the demonstration project under this subsection to—

''(i) assess the timeliness and efficacy of the demonstration project;

''(ii) assess the performance of entities under a contract entered into under paragraph (2)(I)(i);

''(iii) analyze data—

''(I) on the rates of appropriate, uncertain, and inappropriate advanced diagnostic imaging services furnished by physicians participating in the demonstration project;

''(II) on patterns and trends in the appropriateness and inappropriateness of such services furnished by such physicians;

''(III) on patterns and trends in national and regional variations of care with respect to the furnishing of such services; and

''(IV) on the correlation between the appropriateness of the services furnished and image results; and

''(iv) address—

''(I) the thresholds used under the demonstration project to identify acceptable and outlier levels of performance with respect to the appropriateness of advanced diagnostic imaging services furnished;

''(II) whether prospective use of appropriateness criteria could have an effect on the volume of such services furnished;

''(III) whether expansion of the use of appropriateness criteria with respect to such services to a broader population of Medicare beneficiaries would be advisable;

''(IV) whether, under such an expansion, physicians who demonstrate consistent compliance with such appropriateness criteria should be exempted from certain requirements;

''(V) the use of incident-specific versus practice-specific outlier information in formulating future

recommendations with respect to the use of appropriateness criteria for such services under the Medicare program; and

''(VI) the potential for using methods (including financial incentives), in addition to those used under the models under the demonstration project, to ensure compliance with such criteria.

''(B) REPORT.—Not later than 1 year after the completion of the demonstration project under this subsection, the Secretary shall submit to Congress a report containing the results of the evaluation of the demonstration project conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(6) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $10,000,000, for carrying out the demonstration project under this subsection (including costs associated with administering the demonstration project, reimbursing physicians for administrative costs and providing incentives to encourage participation under paragraph (2)(C), entering into contracts under paragraph (2)(I), and evaluating the demonstration project under paragraph (5)).''

AIR AMBULANCE PAYMENT IMPROVEMENTS

Pub. L. 110–275, title I, § 146(b)(1), July 15, 2008, 122 Stat. 2548, as amended by Pub. L. 111–148, title III, § 3105(b), title X, § 10311(b), Mar. 23, 2010, 124 Stat. 417, 943; Pub. L. 111–309, title I, § 106(b), Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, § 306(b), Dec. 23, 2011, 125 Stat. 1285; Pub. L. 112–96, title III, § 3007(b), Feb. 22, 2012, 126 Stat. 190; Pub. L. 112–240, title VI, § 604(b), Jan. 2, 2013, 126 Stat. 2348, provided that: ''Notwithstanding any other provision of law, for purposes of making payments under section 1834(*l*) of the Social Security Act (42 U.S.C. 1395m(*l*)) for air ambulance services furnished during the period beginning on July 1, 2008, and ending on June 30, 2013, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished during such period.''

EVALUATION OF CERTAIN CODE

Pub. L. 110–275, title I, § 154(c)(3), July 15, 2008, 122 Stat. 2566, provided that: ''The Secretary of Health and Human Services shall evaluate the existing Health Care Common Procedure Coding System (HCPCS) codes for negative pressure wound therapy to ensure accurate reporting and billing for items and services under such codes. In carrying out such evaluation, the Secretary shall use an existing process, administered by the Durable Medical Equipment Medicare Administrative Contractors, for the consideration of coding changes and consider all relevant studies and information furnished pursuant to such process.''

GAO REPORT ON CLASS III MEDICAL DEVICES

Pub. L. 108–173, title III, § 302(c)(1)(B), Dec. 8, 2003, 117 Stat. 2231, provided that: ''Not later than March 1, 2006, the Comptroller General of the United States shall submit to Congress, and transmit to the Secretary [of Health and Human Services], a report containing recommendations on the appropriate update percentage under section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) for class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(a)(1)(C) [360c(a)(1)(C)]) furnished to medicare beneficiaries during 2007 and 2008.''

USE OF DATA

Pub. L. 108–173, title IV, § 414(c)(2), Dec. 8, 2003, 117 Stat. 2280, provided that: ''In order to promptly implement section 1834(*l*)(12) of the Social Security Act [42 U.S.C. 1395m(*l*)(12)], as added by paragraph (1), the Secretary [of Health and Human Services] may use data furnished by the Comptroller General of the United States.''

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title IV, § 414(e), Dec. 8, 2003, 117 Stat. 2280, provided that: ''The Secretary [of Health and Human Services] may implement the amendments made by this section [amending this section, section 1395x of this title, and provisions set out as a note under this section], and revise the conversion factor applicable under section 1834(*l*) of the Social Security Act (42 U.S.C. 1395m(*l*)) for purposes of implementing such amendments, on an interim final basis, or by program instruction.''

GAO REPORT ON COSTS AND ACCESS

Pub. L. 108–173, title IV, § 414(f), Dec. 8, 2003, 117 Stat. 2280, which required the Comptroller General of the United States to submit to Congress initial and final reports on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule under section 1395m(*l*) of this title, was repealed by Pub. L. 111–68, div. A, title I, § 1501(e)(1), Oct. 1, 2009, 123 Stat. 2041.

REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT

Pub. L. 108–173, title IV, § 418, Dec. 8, 2003, 117 Stat. 2283, provided that:

''(a) EVALUATION.—The Secretary [of Health and Human Services], acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))[)] are treated as originating sites for telehealth services.

''(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

''(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES.—Insofar as the Secretary concludes in the report required under subsection (b) that it is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006.''

PAYMENT FOR NEW TECHNOLOGIES

Pub. L. 106–554, § 1(a)(6) [title I, § 104(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–470, as amended by Pub. L. 108–173, title IX, § 900(e)(6)(H), Dec. 8, 2003, 117 Stat. 2374, provided that:

''(1) TESTS FURNISHED IN 2001.—

''(A) SCREENING.—For a screening mammography (as defined in section 1861(jj) of the Social Security

Act (42 U.S.C. 1395x(jj))) furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology, payment for such screening mammography shall be made as follows:

''(i) In the case of a technology which directly takes a digital image (without involving film), in an amount equal to 150 percent of the amount of payment under section 1848 of such Act (42 U.S.C. 1395w–4) for a bilateral diagnostic mammography (under HCPCS code 76091) for such year.

''(ii) In the case of a technology which allows conversion of a standard film mammogram into a digital image and subsequently analyzes such resulting image with software to identify possible problem areas, in an amount equal to the limit that would otherwise be applied under section 1834(c)(3) of such Act (42 U.S.C. 1395m(c)(3)) for 2001, increased by $15.

''(B) BILATERAL DIAGNOSTIC MAMMOGRAPHY.—For a bilateral diagnostic mammography furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology described in subparagraph (A), payment for such mammography shall be the amount of payment provided for under such subparagraph.

''(C) ALLOCATION OF AMOUNTS.—The Secretary shall provide for an appropriate allocation of the amounts under subparagraphs (A) and (B) between the professional and technical components.

''(D) IMPLEMENTATION OF PROVISION.—The Secretary of Health and Human Services may implement the provisions of this paragraph by program memorandum or otherwise.

''(2) CONSIDERATION OF NEW HCPCS CODE FOR NEW TECHNOLOGIES AFTER 2001.—The Secretary shall determine, for such mammographies performed after 2001, whether the assignment of a new HCPCS code is appropriate for mammography that uses a new technology. If the Secretary determines that a new code is appropriate for such mammography, the Secretary shall provide for such new code for such tests furnished after 2001.

''(3) NEW TECHNOLOGY DESCRIBED.—For purposes of this subsection, a new technology with respect to a mammography is an advance in technology with respect to the test or equipment that results in the following:

''(A) A significant increase or decrease in the resources used in the test or in the manufacture of the equipment.

''(B) A significant improvement in the performance of the test or equipment.

''(C) A significant advance in medical technology that is expected to significantly improve the treatment of medicare beneficiaries.

''(4) HCPCS CODE DEFINED.—The term 'HCPCS code' means a code under the Health Care Common Procedure Coding System (HCPCS).''

MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES

Pub. L. 106–554, §1(a)(6) [title I, §127], Dec. 21, 2000, 114 Stat. 2763, 2763A–479, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on coverage of cardiac and pulmonary rehabilitation therapy services under the medicare program under title XVIII of the Social Security Act [this subchapter].

''(2) FOCUS.—In conducting the study under paragraph (1), the Commission shall focus on the appropriate—

''(A) qualifying diagnoses required for coverage of cardiac and pulmonary rehabilitation therapy services;

''(B) level of physician direct involvement and supervision in furnishing such services; and

''(C) level of reimbursement for such services.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Commission determines appropriate.''

GAO STUDIES ON COSTS OF AMBULANCE SERVICES FURNISHED IN RURAL AREAS

Pub. L. 106–554, §1(a)(6) [title II, §221(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that:

''(1) STUDY.—The Comptroller General of the United States shall conduct a study on each of the matters described in paragraph (2).

''(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are the following:

''(A) The cost of efficiently providing ambulance services for trips originating in rural areas, with special emphasis on collection of cost data from rural providers.

''(B) The means by which rural areas with low population densities can be identified for the purpose of designating areas in which the cost of providing ambulance services would be expected to be higher than similar services provided in more heavily populated areas because of low usage. Such study shall also include an analysis of the additional costs of providing ambulance services in areas designated under the previous sentence.

''(3) REPORT.—Not later than June 30, 2002, the Comptroller General shall submit to Congress a report on the results of the studies conducted under paragraph (1) and shall include recommendations on steps that should be taken to assure access to ambulance services in rural areas.''

ADJUSTMENT IN RURAL RATES

Pub. L. 106–554, §1(a)(6) [title II, §221(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, as amended by Pub. L. 108–173, title IV, §414(f)(1), formerly §414(g)(1), Dec. 8, 2003, 117 Stat. 2281, as renumbered by Pub. L. 111–68, div. A, title I, §1501(e)(2), Oct. 1, 2009, 123 Stat. 2041, provided that: ''In providing for adjustments under subparagraph (D) of section 1834(*l*)(2) of the Social Security Act (42 U.S.C. 1395m(*l*)(2)) for years beginning with 2004, the Secretary of Health and Human Services shall take into consideration the recommendations contained in the report under subsection (b)(3) [set out above] and shall adjust the fee schedule payment rates under such section for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.''

STUDY AND REPORT ON ADDITIONAL COVERAGE FOR TELEHEALTH SERVICES

Pub. L. 106–554, §1(a)(6) [title II, §223(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–489, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify—

''(A) settings and sites for the provision of telehealth services that are in addition to those permitted under section 1834(m) of the Social Security Act [42 U.S.C. 1395m(m)], as added by subsection (b);

''(B) practitioners that may be reimbursed under such section for furnishing telehealth services that are in addition to the practitioners that may be reimbursed for such services under such section; and

''(C) geographic areas in which telehealth services may be reimbursed that are in addition to the geographic areas where such services may be reimbursed under such section.

''(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation that the Secretary determines are appropriate.''

SPECIAL RULES FOR PAYMENTS FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §423(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: ''Notwith-

standing the amendment made by paragraph (1) [amending this section], for purposes of making payments for ambulance services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], for services furnished during 2001, the 'percentage increase in the consumer price index' specified in section 1834(*l*)(3)(B) of such Act (42 U.S.C. 1395m(*l*)(3)(B))—

''(A) for services furnished on or after January 1, 2001, and before July 1, 2001, shall be the percentage increase for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(B) for services furnished on or after July 1, 2001, and before January 1, 2002, shall be equal to 4.7 percent.''

Pub. L. 106–554, §1(a)(6) [title IV, §425(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–519, provided that: ''Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for durable medical equipment under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), other than for oxygen and oxygen equipment specified in paragraph (9) of such section, the payment basis recognized for 2001 under such section—

''(1) for items furnished on or after January 1, 2001, and before July 1, 2001, shall be the payment basis for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000] (including the application of section 228(a)(1) of BBRA [Pub. L. 106–113, §1000(a)(6) [title II, §228(a)(1)], set out as a note below]); and

''(2) for items furnished on or after July 1, 2001, and before January 1, 2002, shall be the payment basis that is determined under such section 1834(a) if such section 228(a)(1) did not apply and taking into account the amendment made by subsection (a), increased by a transitional percentage allowance equal to 3.28 percent (to account for the timing of implementation of the CPI update).''

Pub. L. 106–554, §1(a)(6) [title IV, §426(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–520, provided that: ''Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for prosthetic devices and orthotics and prosthetics (as defined in subparagraphs (B) and (C) of paragraph (4) of section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) under such section, the payment basis recognized for 2001 under paragraph (2) of such section—

''(1) for items furnished on or after January 1, 2001, and before July 1, 2001, shall be the payment basis for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for items furnished on or after July 1, 2001, and before January 1, 2002, shall be the payment basis that is determined under such section taking into account the amendments made by subsection (a), increased by a transitional percentage allowance equal to 2.6 percent (to account for the timing of implementation of the CPI update).''

Preemption of Rule

Pub. L. 106–554, §1(a)(6) [title IV, §428(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that: ''The provisions of section 1834(h)(1)(G) [42 U.S.C. 1395m(h)(1)(G)] as added by subsection (a) shall supersede any rule that as of the date of the enactment of this Act [Dec. 21, 2000] may have applied a 5-year replacement rule with regard to prosthetic devices.''

GAO Study and Report on Costs of Emergency and Medical Transportation Services

Pub. L. 106–554, §1(a)(6) [title IV, §436], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

''(a) Study.—The Comptroller General of the United States shall conduct a study on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

''(b) Report.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for any changes in methodology or payment level necessary to fairly compensate suppliers of emergency and medical transportation services and to ensure the access of beneficiaries under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

Treatment of Temporary Payment Increases After Calendar Year 2001

Pub. L. 106–554, §1(a)(6) [title V, §547(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that: ''The payment increase provided under the following sections shall not apply after calendar year 2001 and shall not be taken into account in calculating the payment amounts applicable for items and services furnished after such year:

''(1) Section 401(c)(2) [set out as a note under section 1395*l* of this title] (relating to covered OPD services).

''(2) Section 422(e)(2) [set out as a note under section 1395rr of this title] (relating to renal dialysis services paid for on a composite rate basis).

''(3) Section 423(a)(2)(B) [set out above] (relating to ambulance services).

''(4) Section 425(b)(2) [set out above] (relating to durable medical equipment).

''(5) Section 426(b)(2) [set out above] (relating to prosthetic devices and orthotics and prosthetics).''

Study of Delivery of Intravenous Immune Globulin (IVIG) Outside Hospitals and Physicians' Offices

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(n)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, required the Secretary of Health and Human Services to conduct a study of the extent to which intravenous immune globulin could be delivered and reimbursed under the medicare program outside of a hospital or physician's office and to submit a report on such study to Congress within 18 months after Nov. 29, 1999.

Temporary Increase in Payment Rates for Durable Medical Equipment and Oxygen

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §228], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, provided that:

''(a) In General.—For purposes of payments under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) for covered items (as defined in paragraph (13) of that section) furnished during 2001 and 2002, the Secretary of Health and Human Services shall increase the payment amount in effect (but for this section) for such items for—

''(1) 2001 by 0.3 percent, and

''(2) 2002 by 0.6 percent.

''(b) Limiting Application to Specified Years.—The payment amount increase—

''(1) under subsection (a)(1) shall not apply after 2001 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year; and

''(2) under subsection (a)(2) shall not apply after 2002 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year.''

Demonstration of Coverage of Ambulance Services Under Medicare Through Contracts With Units of Local Government

Pub. L. 105–33, title IV, §4532, Aug. 5, 1997, 111 Stat. 453, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §225], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, provided that:

''(a) Demonstration Project Contracts with Local Governments.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects

under which, at the request of a unit of local government, the Secretary enters into a contract with the unit of local government under which—

''(1) the unit of local government furnishes (or arranges for the furnishing of) ambulance services for which payment may be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for individuals residing in the unit of local government who are enrolled under such part, except that the unit of local government may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the unit of local government who are enrolled under such part but not in a Medicare+Choice plan;

''(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

''(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the unit of local government in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each. Not later than July 1, 2000, the Secretary shall publish a request for proposals for such projects.

''(b) AMOUNT OF PAYMENT.—

''(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a unit of local government under a demonstration project contract under subsection (a) shall be equal to the product of—

''(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

''(B) 1/12 of the capitated payment rate for the year established under paragraph (2).

''(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the term 'capitated payment rate' means, with respect to a demonstration project—

''(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in the local area of government's jurisdiction; and

''(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.

''(c) OTHER TERMS OF CONTRACT.—The Secretary and the unit of local government may include in a contract under this section such other terms as the parties consider appropriate, including—

''(1) covering individuals residing in additional units of local government (under arrangements entered into between such units and the unit of local government involved);

''(2) permitting the unit of local government to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

''(3) implementing such other innovations as the unit of local government may propose to improve the quality of ambulance services and control the costs of such services.

''(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a unit of local government under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the services covered under the contract which are furnished to individuals who reside in the unit of local government.

''(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

''(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

''(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.''

[References to Medicare+Choice deemed to refer to Medicare Advantage, see section 201(b) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.]

[Pub. L. 106–113, div. B, §1000(a)(6) [title II, §225], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, provided that the amendment made by that section to section 4532 of Pub. L. 105–33, set out above, is effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33.]

PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT

Pub. L. 105–33, title IV, §4551(b), Aug. 5, 1997, 111 Stat. 458, provided that: ''In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.''

SERVICE STANDARDS FOR PROVIDERS OF OXYGEN AND OXYGEN EQUIPMENT

Pub. L. 105–33, title IV, §4552(c), Aug. 5, 1997, 111 Stat. 459, provided that: ''The Secretary shall as soon as practicable establish service standards for persons seeking payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the providing of oxygen and oxygen equipment to beneficiaries within their homes.''

ACCESS TO HOME OXYGEN EQUIPMENT

Pub. L. 105–33, title IV, §4552(d), Aug. 5, 1997, 111 Stat. 459, provided that:

''(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 18 months after the date of the enactment of this Act [Aug. 5, 1997], report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

''(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review [now ''quality improvement''] organizations established under section 1154 of the Social Security Act [42 U.S.C. 1320c–3] to evaluate access to, and quality of, home oxygen equipment.''

USE OF COVERED ITEMS BY DISABLED BENEFICIARIES

Pub. L. 103–432, title I, §131(b), Oct. 31, 1994, 108 Stat. 4419, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment under part B of the medicare program [42 U.S.C. 1395j et seq.] and individuals entitled to benefits under such program on the basis of disability, shall conduct a study of the effects of the methodology for determining payments for items of such equipment under such part on the ability of such individuals to obtain items of such equipment, including customized items.

''(2) REPORT.—Not later than one year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary con-

siders appropriate to assure that disabled medicare beneficiaries have access to items of durable medical equipment.''

CRITERIA FOR TREATMENT OF ITEMS AS PROSTHETIC DEVICES OR ORTHOTICS AND PROSTHETICS

Pub. L. 103–432, title I, § 131(c), Oct. 31, 1994, 108 Stat. 4419, provided that not later than one year after Oct. 31, 1994, Secretary of Health and Human Services was to submit to Congress a report describing prosthetic devices or orthotics and prosthetics covered under this part that do not require individualized or custom fitting and adjustment to be used by a patient, including recommendations for appropriate methodology for determining amount of payment for such items.

ADJUSTMENT REQUIRED FOR CERTAIN ITEMS

Pub. L. 103–432, title I, § 134(b), Oct. 31, 1994, 108 Stat. 4422, provided that:

''(1) IN GENERAL.—In accordance with section 1834(a)(10)(B) of the Social Security Act [42 U.S.C. 1395m(a)(10)(B)] (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

''(2) ITEMS DESCRIBED.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary.''

LIMITATION ON PREVAILING CHARGE FOR PHYSICIANS' RADIOLOGY SERVICES FURNISHED DURING 1991; EXCEPTIONS

Pub. L. 101–508, title IV, § 4102(c), Nov. 5, 1990, 104 Stat. 1388–57, as amended by Pub. L. 103–432, title I, § 126(b)(3), Oct. 31, 1994, 108 Stat. 4415, provided that:

''(1) IN GENERAL.—In applying part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], the prevailing charge for physicians' services, furnished during 1991, which are radiology services may not exceed the fee schedule amount established under section 1834(b) of such Act [42 U.S.C. 1395m(b)] with respect to such services.

''(2) EXCEPTION.—Paragraph (1) shall not apply to nuclear medicine services.''

LIMITATION ON CARRIER ADJUSTMENTS FOR RADIOLOGIST SERVICES FURNISHED DURING 1991

Pub. L. 101–508, title IV, § 4102(e), Nov. 5, 1990, 104 Stat. 1388–57, provided that: ''For radiologist services furnished during 1991 for which payment is made under section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)]—

''(1) a carrier may not make any adjustment, under section 1842(b)(3)(B) of such Act [42 U.S.C. 1395u(b)(3)(B)], in the payment amount for the service under section 1834(b) on the basis that the payment amount is higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier,

''(2) no payment adjustment may be made under section 1842(b)(8) of such Act, and

''(3) section 1842(b)(9) of such Act shall not apply.''

STUDY OF PAYMENTS FOR PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS

Pub. L. 101–508, title IV, § 4153(c), Nov. 9, 1990, 104 Stat. 1388–84, as amended by Pub. L. 103–432, title I, § 135(e)(6), Oct. 31, 1994, 108 Stat. 4424, directed Comptroller General to conduct a study of feasibility and desirability of establishing a separate fee schedule for use in determining the amount of payments for covered items under subsec. (h) of this section with respect to suppliers of prosthetic devices, orthotics, and prosthetics who provide professional services that would take into account the costs to such providers of providing such services and, not later than 1 year after Nov. 5, 1990, submit a report on the study to Committees on Energy and Commerce and Ways and Means of House of Representatives and Committee on Finance of Senate, including any recommendations regarding payments for prosthetic devices, orthotics, and prosthetics under the medicare program.

SPECIAL RULE FOR NUCLEAR MEDICINE PHYSICIANS

Pub. L. 101–239, title VI, § 6105(b), Dec. 19, 1989, 103 Stat. 2210, as amended by Pub. L. 101–508, title IV, § 4102(g)(1), Nov. 5, 1990, 104 Stat. 1388–57, provided that: ''In applying section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)] with respect to nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the total amount of charges made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] beginning April 1, 1990, and ending December 31, 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based ⅓ on the fee schedule computed under such section (without regard to this subsection) and ⅔ on 101 percent of the 1988 prevailing charge for such services.''

SPECIAL RULE FOR INTERVENTIONAL RADIOLOGISTS; ''SPLIT BILLING''

Pub. L. 101–239, title VI, § 6105(c), Dec. 19, 1989, 103 Stat. 2210, as amended by Pub. L. 101–508, title IV, § 4102(h), Nov. 5, 1990, 104 Stat. 1388–58, provided that: ''In applying section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)] to radiologist services furnished in 1990 or 1991, the exception for 'split billing' set forth at section 5262J of the Medicare Carriers Manual shall apply to services furnished in 1990 or 1991 in the same manner and to the same extent as the exception applied to services furnished in 1989.''

RENTAL PAYMENTS FOR ENTERAL AND PARENTERAL PUMPS

Pub. L. 101–239, title VI, § 6112(b), Dec. 19, 1989, 103 Stat. 2215, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amount of any monthly rental payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for an enteral or parenteral pump furnished on or after April 1, 1990, shall be determined in accordance with the methodology under which monthly rental payments for such pumps were determined during 1989.

''(2) CAP ON RENTAL PAYMENTS, SERVICING, AND REPAIRS.—In the case of an enteral or parenteral pump described in paragraph (1) that is furnished on a rental basis during a period of medical need—

''(A) monthly rental payments shall not be made under part B of title XVIII of the Social Security Act for more than 15 months during such period, and

''(B) after monthly rental payments have been made for 15 months during such period, payment under such part shall be made for maintenance and servicing of the pump in such amounts as the Secretary of Health and Human Services determines to be reasonable and necessary to ensure the proper operation of the pump.''

TREATMENT OF POWER-DRIVEN WHEELCHAIRS AS CUSTOMIZED ITEMS

Pub. L. 101–239, title VI, § 6112(d)(2), Dec. 19, 1989, 103 Stat. 2215, provided that: ''The Secretary of Health and Human Services shall by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in section 1834(a)(4) of the Social Security Act [42 U.S.C. 1395m(a)(4)]) for purposes of reimbursement under title XVIII of such Act [42 U.S.C. 1395 et seq.].''

STUDY OF PAYMENT FOR PORTABLE X-RAY SERVICES

Pub. L. 101–239, title VI, § 6134, Dec. 19, 1989, 103 Stat. 2222, directed Secretary of Health and Human Services

to conduct a study of costs of furnishing, and payments for, portable x-ray services under part B and, not later than 1 year after Dec. 19, 1989, report to Congress on results of such study including a recommendation respecting whether payment for such services should be made in the same manner as for radiologists' services or on the basis of a separate fee schedule.

GAO STUDY OF STANDARDS FOR USE OF AND PAYMENT FOR ITEMS OF DURABLE MEDICAL EQUIPMENT

Pub. L. 101–239, title VI, § 6139, Dec. 19, 1989, 103 Stat. 2224, directed Comptroller General to conduct a study of appropriate uses of items of durable medical equipment and of appropriate criteria for making determinations of medical necessity under this subchapter for such items, with particular emphasis on items (including seat-lift chairs) that may be subject to abusive billing practices, such study to include an analysis of appropriate use of forms in making medical necessity determinations for items of durable medical equipment under such title, and procedures for identifying items of durable medical equipment that should no longer be covered under this subchapter, and to be conducted with a panel convened by the Comptroller General consisting of specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine, representatives of consumer organizations, and representatives of carriers under the medicare program, with the Comptroller General to submit not later than Apr. 1, 1991, a report to Committees on Ways and Means and Energy and Commerce of House of Representatives and Committee on Finance of Senate on the study including recommendations.

REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES

Pub. L. 100–360, title II, § 202(i), July 1, 1988, 102 Stat. 718, directed Secretary of Health and Human Services, by not later than Apr. 1, 1989, to report to Congress on expenses incurred by medicare beneficiaries for outpatient prescription drugs, and to provide Director of Congressional Budget Office with such data from that Survey as Director might request to make required estimates, prior to repeal by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

ADDITIONAL STUDIES BY SECRETARY OR COMPTROLLER GENERAL

Pub. L. 100–360, title II, § 202(k), July 1, 1988, 102 Stat. 719, directed Secretary of Health and Human Services to conduct a study, and make a report to Congress by Jan. 1, 1990, on possibility of including drugs which have not yet been approved under section 355 or 357 of Title 21, Food and Drugs, and biological products which have not been licensed under section 262 of this title but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under medicare program, to conduct a study, and report to Congress by Jan. 1, 1990, evaluating potential to use mail service pharmacies to reduce costs to medicare program and to medicare beneficiaries, to conduct a study, and report to Congress by Jan. 1, 1993, on methods to improve utilization review of covered outpatient drugs, and to conduct a longitudinal study, and report to Congress by Jan. 1, 1993, on use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, and which further directed Comptroller General to conduct studies, and report to Congress by not later than May 1, 1991, on comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy, on determining the overhead costs of retail pharmacies, and on discounts given by pharmacies to other third-party insurers, prior to repeal by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

DEVELOPMENT OF STANDARD MEDICARE CLAIMS FORMS

Pub. L. 100–360, title II, § 202(*l*), July 1, 1988, 102 Stat. 720, directed Secretary of Health and Human Services to develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under medicare program and other third-party payors, prior to repeal by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDIES AND REPORTS ON SCREENING MAMMOGRAPHY

Pub. L. 100–360, title II, § 204(f), July 1, 1988, 102 Stat. 729, directed Physician Payment Review Commission to study and report, by July 1, 1989, to Committees on Ways and Means and Energy and Commerce of the House of Representatives and Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels, prior to repeal by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

DEADLINE FOR ESTABLISHMENT OF FEE SCHEDULES FOR RADIOLOGIST SERVICES; REPORT TO CONGRESS

Pub. L. 100–203, title IV, § 4049(b)(1), Dec. 22, 1987, 101 Stat. 1330–92, as amended by Pub. L. 100–360, title IV, § 411(f)(8)(E), July 1, 1988, 102 Stat. 780; Pub. L. 101–508, title IV, § 4118(g)(3), Nov. 5, 1990, 104 Stat. 1388–70, directed Secretary of Health and Human Services to propose the relative value scale and fee schedules for radiologist services (under subsec. (b) of this section) by not later than Aug. 1, 1988.

STUDY AND EVALUATION

Pub. L. 100–203, title IV, § 4062(c), Dec. 22, 1987, 101 Stat. 1330–107, as amended by Pub. L. 100–360, title IV, § 411(g)(1)(C), July 1, 1988, 102 Stat. 782, provided that:

''(1) The Secretary of Health and Human Services shall monitor the impact of the amendments made by this section [enacting this section, amending sections 1395f, 1395k, 1395*l*, and 1395cc of this title, and repealing section 1395zz of this title] on the availability of covered items and shall evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment under section 1834(a)(5)(C) of the Social Security Act [42 U.S.C. 1395m(a)(5)(C)] (as amended by subsection (b) of this section). The Secretary shall report to Congress, by not later than January 1, 1991, on such impact and on the evaluation and shall include in such report recommendations for changes in payment methodology for covered items under section 1834(a) of such Act.

''(2) Before January 1, 1991, the Secretary may not conduct any demonstration project respecting alternative methods of payment for covered items under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(3) In this subsection, the term 'covered item' has the meaning given such term in section 1834(a)(13) of the Social Security Act [42 U.S.C. 1395m(a)(13)] (as amended by subsection (b) of this section).

''(4) The Secretary shall, upon written request and payment of a reasonable copying fee which the Secretary may establish, provide the data and information used in determining the payment amounts for covered items under section 1834(a) of the Social Security Act [42 U.S.C. 1395m(a)], but only in a form which does not permit identification of individual suppliers.

''(5) The Comptroller General shall conduct a study on the appropriateness of the level of payments allowed for covered items under the medicare program, and shall report to Congress on the results of such study (including recommendations on the transition to regional or national rates) by not later than January 1, 1991. Entities furnishing such items which fail to provide the Comptroller General with reasonable access to necessary records to carry out the study under this paragraph are subject to exclusion from the medicare program under section 1128(a) of the Social Security Act [42 U.S.C. 1320a–7(a)].''

§ 1395m–1. Improving policies for clinical diagnostic laboratory tests

(a) Reporting of private sector payment rates for establishment of medicare payment rates

(1) In general

(A) General reporting requirements

Subject to subparagraph (B), beginning January 1, 2016, and every 3 years thereafter (or, annually, in the case of reporting with respect to an advanced diagnostic laboratory test, as defined in subsection (d)(5)), an applicable laboratory (as defined in paragraph (2)) shall report to the Secretary, at a time specified by the Secretary (referred to in this subsection as the ''reporting period''), applicable information (as defined in paragraph (3)) for a data collection period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

(B) Revised reporting period

In the case of reporting with respect to clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests, the Secretary shall revise the reporting period under subparagraph (A) such that—

(i) no reporting is required during the period beginning January 1, 2020, and ending December 31, 2022;

(ii) reporting is required during the period beginning January 1, 2023, and ending March 31, 2023; and

(iii) reporting is required every three years after the period described in clause (ii).

(2) Definition of applicable laboratory

In this section, the term ''applicable laboratory'' means a laboratory that, with respect to its revenues under this subchapter, a majority of such revenues are from this section, section 1395*l*(h) of this title, or section 1395w–4 of this title. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

(3) Applicable information defined

(A) In general

In this section, subject to subparagraph (B), the term ''applicable information'' means, with respect to a laboratory test for a data collection period, the following:

(i) The payment rate (as determined in accordance with paragraph (5)) that was paid by each private payor for the test during the period.

(ii) The volume of such tests for each such payor for the period.

(B) Exception for certain contractual arrangements

Such term shall not include information with respect to a laboratory test for which payment is made on a capitated basis or other similar payment basis during the data collection period.

(4) Data collection period defined

(A) In general

Subject to subparagraph (B), in this section, the term ''data collection period'' means a period of time, such as a previous 12 month period, specified by the Secretary.

(B) Exception

In the case of the reporting period described in paragraph (1)(B)(ii) with respect to clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests, the term ''data collection period'' means the period beginning January 1, 2019, and ending June 30, 2019.

(5) Treatment of discounts

The payment rate reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1395w–3a(c)(3) of this title.

(6) Ensuring complete reporting

In the case where an applicable laboratory has more than one payment rate for the same payor for the same test or more than one payment rate for different payors for the same test, the applicable laboratory shall report each such payment rate and the volume for the test at each such rate under this subsection. Beginning with January 1, 2019, the Secretary may establish rules to aggregate reporting with respect to the situations described in the preceding sentence.

(7) Certification

An officer of the laboratory shall certify the accuracy and completeness of the information reported under this subsection.

(8) Private payor defined

In this section, the term ''private payor'' means the following:

(A) A health insurance issuer and a group health plan (as such terms are defined in section 300gg–91 of this title).

(B) A Medicare Advantage plan under part C.

(C) A medicaid managed care organization (as defined in section 1396b(m) of this title).

(9) Civil money penalty

(A) In general

If the Secretary determines that an applicable laboratory has failed to report or made a misrepresentation or omission in reporting information under this subsection with respect to a clinical diagnostic laboratory test, the Secretary may apply a civil money penalty in an amount of up to $10,000 per day for each failure to report or each such misrepresentation or omission.

(B) Application

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

(10) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by a laboratory under

this subsection is confidential and shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payor or laboratory, or prices charged or payments made to any such laboratory, except—

(A) as the Secretary determines to be necessary to carry out this section;

(B) to permit the Comptroller General to review the information provided;

(C) to permit the Director of the Congressional Budget Office to review the information provided; and

(D) to permit the Medicare Payment Advisory Commission to review the information provided.

(11) Protection from public disclosure

A payor shall not be identified on information reported under this subsection. The name of an applicable laboratory under this subsection shall be exempt from disclosure under section 552(b)(3) of title 5.

(12) Regulations

Not later than June 30, 2015, the Secretary shall establish through notice and comment rulemaking parameters for data collection under this subsection.

(b) Payment for clinical diagnostic laboratory tests

(1) Use of private payor rate information to determine medicare payment rates

(A) In general

Subject to paragraph (3) and subsections (c) and (d), in the case of a clinical diagnostic laboratory test furnished on or after January 1, 2017, the payment amount under this section shall be equal to the weighted median determined for the test under paragraph (2) for the most recent data collection period.

(B) Application of payment amounts to hospital laboratories

The payment amounts established under this section shall apply to a clinical diagnostic laboratory test furnished by a hospital laboratory if such test is paid for separately, and not as part of a bundled payment under section 1395*l*(t) of this title.

(2) Calculation of weighted median

For each laboratory test with respect to which information is reported under subsection (a) for a data collection period, the Secretary shall calculate a weighted median for the test for the period, by arraying the distribution of all payment rates reported for the period for each test weighted by volume for each payor and each laboratory.

(3) Phase-in of reductions from private payor rate implementation

(A) In general

Payment amounts determined under this subsection for a clinical diagnostic laboratory test for each of 2017 through 2025 shall not result in a reduction in payments for a clinical diagnostic laboratory test for the year of greater than the applicable percent (as defined in subparagraph (B)) of the amount of payment for the test for the preceding year.

(B) Applicable percent defined

In this paragraph, the term ''applicable percent'' means—

(i) for each of 2017 through 2020, 10 percent;

(ii) for each of 2021 and 2022, 0 percent; and

(iii) for each of 2023 through 2025, 15 percent.

(C) No application to new tests

This paragraph shall not apply to payment amounts determined under this section for either of the following.

(i) A new test under subsection (c).

(ii) A new advanced diagnostic test[1] (as defined in subsection (d)(5)) under subsection (d).

(4) Application of market rates

(A) In general

Subject to paragraph (3), once established for a year following a data collection period, the payment amounts under this subsection shall continue to apply until the year following the next data collection period.

(B) Other adjustments not applicable

The payment amounts under this section shall not be subject to any adjustment (including any geographic adjustment, budget neutrality adjustment, annual update, or other adjustment).

(5) Sample collection fee

In the case of a sample collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, the nominal fee that would otherwise apply under section 1395*l*(h)(3)(A) of this title shall be increased by $2.

(c) Payment for new tests that are not advanced diagnostic laboratory tests

(1) Payment during initial period

In the case of a clinical diagnostic laboratory test that is assigned a new or substantially revised HCPCS code on or after April 1, 2014, and which is not an advanced diagnostic laboratory test (as defined in subsection (d)(5)), during an initial period until payment rates under subsection (b) are established for the test, payment for the test shall be determined—

(A) using cross-walking (as described in section 414.508(a) of title 42, Code of Federal Regulations, or any successor regulation) to the most appropriate existing test under the fee schedule under this section during that period; or

(B) if no existing test is comparable to the new test, according to the gapfilling process described in paragraph (2).

(2) Gapfilling process described

The gapfilling process described in this paragraph shall take into account the following

[1] So in original. Probably should be preceded by ''laboratory''.

sources of information to determine gapfill amounts, if available:

(A) Charges for the test and routine discounts to charges.

(B) Resources required to perform the test.

(C) Payment amounts determined by other payors.

(D) Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

(E) Other criteria the Secretary determines appropriate.

(3) Additional consideration

In determining the payment amount under crosswalking or gapfilling processes under this subsection, the Secretary shall consider recommendations from the panel established under subsection (f)(1).

(4) Explanation of payment rates

In the case of a clinical diagnostic laboratory test for which payment is made under this subsection, the Secretary shall make available to the public an explanation of the payment rate for the test, including an explanation of how the criteria described in paragraph (2) and paragraph (3) are applied.

(d) Payment for new advanced diagnostic laboratory tests

(1) Payment during initial period

(A) In general

In the case of an advanced diagnostic laboratory test for which payment has not been made under the fee schedule under section 1395*l*(h) of this title prior to April 1, 2014, during an initial period of three quarters, the payment amount for the test for such period shall be based on the actual list charge for the laboratory test.

(B) Actual list charge

For purposes of subparagraph (A), the term ''actual list charge'', with respect to a laboratory test furnished during such period, means the publicly available rate on the first day at which the test is available for purchase by a private payor.

(2) Special rule for timing of initial reporting

With respect to an advanced diagnostic laboratory test described in paragraph (1)(A), an applicable laboratory shall initially be required to report under subsection (a) not later than the last day of the second quarter of the initial period under such paragraph.

(3) Application of market rates after initial period

Subject to paragraph (4), data reported under paragraph (2) shall be used to establish the payment amount for an advanced diagnostic laboratory test after the initial period under paragraph (1)(A) using the methodology described in subsection (b). Such payment amount shall continue to apply until the year following the next data collection period.

(4) Recoupment if actual list charge exceeds market rate

With respect to the initial period described in paragraph (1)(A), if, after such period, the Secretary determines that the payment amount for an advanced diagnostic laboratory test under paragraph (1)(A) that was applicable during the period was greater than 130 percent of the payment amount for the test established using the methodology described in subsection (b) that is applicable after such period, the Secretary shall recoup the difference between such payment amounts for tests furnished during such period.

(5) Advanced diagnostic laboratory test defined

In this subsection, the term ''advanced diagnostic laboratory test'' means a clinical diagnostic laboratory test covered under this part that is offered and furnished only by a single laboratory and not sold for use by a laboratory other than the original developing laboratory (or a successor owner) and meets one of the following criteria:

(A) The test is an analysis of multiple biomarkers of DNA, RNA, or proteins combined with a unique algorithm to yield a single patient-specific result.

(B) The test is cleared or approved by the Food and Drug Administration.

(C) The test meets other similar criteria established by the Secretary.

(e) Coding

(1) Temporary codes for certain new tests

(A) In general

The Secretary shall adopt temporary HCPCS codes to identify new advanced diagnostic laboratory tests (as defined in subsection (d)(5)) and new laboratory tests that are cleared or approved by the Food and Drug Administration.

(B) Duration

(i) In general

Subject to clause (ii), the temporary code shall be effective until a permanent HCPCS code is established (but not to exceed 2 years).

(ii) Exception

The Secretary may extend the temporary code or establish a permanent HCPCS code, as the Secretary determines appropriate.

(2) Existing tests

Not later than January 1, 2016, for each existing advanced diagnostic laboratory test (as so defined) and each existing clinical diagnostic laboratory test that is cleared or approved by the Food and Drug Administration for which payment is made under this part as of April 1, 2014, if such test has not already been assigned a unique HCPCS code, the Secretary shall—

(A) assign a unique HCPCS code for the test; and

(B) publicly report the payment rate for the test.

(3) Establishment of unique identifier for certain tests

For purposes of tracking and monitoring, if a laboratory or a manufacturer requests a

unique identifier for an advanced diagnostic laboratory test (as so defined) or a laboratory test that is cleared or approved by the Food and Drug Administration, the Secretary shall utilize a means to uniquely track such test through a mechanism such as a HCPCS code or modifier.

(f) Input from clinicians and technical experts

(1) In general

The Secretary shall consult with an expert outside advisory panel, established by the Secretary not later than July 1, 2015, composed of an appropriate selection of individuals with expertise, which may include molecular pathologists, researchers, and individuals with expertise in laboratory science or health economics, in issues related to clinical diagnostic laboratory tests, which may include the development, validation, performance, and application of such tests, to provide—

(A) input on—

(i) the establishment of payment rates under this section for new clinical diagnostic laboratory tests, including whether to use crosswalking or gapfilling processes to determine payment for a specific new test; and

(ii) the factors used in determining coverage and payment processes for new clinical diagnostic laboratory tests; and

(B) recommendations to the Secretary under this section.

(2) Compliance with FACA

The panel shall be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

(3) Continuation of annual meeting

The Secretary shall continue to convene the annual meeting described in section 1395*l*(h)(8)(B)(iii) of this title after the implementation of this section for purposes of receiving comments and recommendations (and data on which the recommendations are based) as described in such section on the establishment of payment amounts under this section.

(g) Coverage

(1) Issuance of coverage policies

(A) In general

A medicare administrative contractor shall only issue a coverage policy with respect to a clinical diagnostic laboratory test in accordance with the process for making a local coverage determination (as defined in section 1395ff(f)(2)(B) of this title), including the appeals and review process for local coverage determinations under part 426 of title 42, Code of Federal Regulations (or successor regulations).

(B) No effect on national coverage determination process

This paragraph shall not apply to the national coverage determination process (as defined in section 1395ff(f)(1)(B) of this title).

(C) Effective date

This paragraph shall apply to coverage policies issued on or after January 1, 2015.

(2) Designation of one or more medicare administrative contractors for clinical diagnostic laboratory tests

The Secretary may designate one or more (not to exceed 4) medicare administrative contractors to either establish coverage policies or establish coverage policies and process claims for payment for clinical diagnostic laboratory tests, as determined appropriate by the Secretary.

(h) Implementation

(1) Implementation

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of the establishment of payment amounts under this section.

(2) Administration

Chapter 35 of title 44 shall not apply to information collected under this section.

(3) Funding

For purposes of implementing this section, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to the Centers for Medicare & Medicaid Services Program Management Account, for each of fiscal years 2014 through 2018, $4,000,000, and for each of fiscal years 2019 through 2023, $3,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

(i) Transitional rule

During the period beginning on April 1, 2014, and ending on December 31, 2016, with respect to advanced diagnostic laboratory tests under this part, the Secretary shall use the methodologies for pricing, coding, and coverage in effect on the day before April 1, 2014, which may include cross-walking or gapfilling methods.

(Aug. 14, 1935, ch. 531, title XVIII, §1834A, as added Pub. L. 113–93, title II, §216(a), Apr. 1, 2014, 128 Stat. 1053; amended Pub. L. 116–94, div. N, title I, §105(a), Dec. 20, 2019, 133 Stat. 3100; Pub. L. 116–136, div. A, title III, §3718, Mar. 27, 2020, 134 Stat. 425; Pub. L. 117–71, §4, Dec. 10, 2021, 135 Stat. 1507.)

Editorial Notes

REFERENCES IN TEXT

The Federal Advisory Committee Act, referred to in subsec. (f)(2), is Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

AMENDMENTS

2021—Subsec. (a)(1)(B)(i). Pub. L. 117–71, §4(b)(1), substituted ''December 31, 2022'' for ''December 31, 2021''.

Subsec. (a)(1)(B)(ii). Pub. L. 117–71, §4(b)(2), substituted ''January 1, 2023'' for ''January 1, 2022'' and ''March 31, 2023'' for ''March 31, 2022''.

Subsec. (b)(3)(A). Pub. L. 117–71, §4(a)(1), substituted ''through 2025'' for ''through 2024''.

Subsec. (b)(3)(B)(ii). Pub. L. 117–71, §4(a)(2)(A), substituted ''for each of 2021 and 2022'' for ''for 2021''.

Subsec. (b)(3)(B)(iii). Pub. L. 117–71, §4(a)(2)(B), substituted ''2023 through 2025'' for ''2022 through 2024''.

2020—Subsec. (a)(1)(B)(i). Pub. L. 116–136, §3718(a)(1), substituted ''December 31, 2021'' for ''December 31, 2020''.

Subsec. (a)(1)(B)(ii). Pub. L. 116–136, §3718(a)(2), substituted ''January 1, 2022'' for ''January 1, 2021'' and ''March 31, 2022'' for ''March 31, 2021''.

Subsec. (b)(3)(A). Pub. L. 116–136, §3718(b)(1), substituted ''through 2024'' for ''through 2023''.

Subsec. (b)(3)(B). Pub. L. 116–136, §3718(b)(2), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted ''2022 through 2024'' for ''2021 through 2023'' in cl. (iii).

2019—Subsec. (a)(1). Pub. L. 116–94, §105(a)(1)(A), designated existing provisions as subpar. (A) and inserted heading, substituted ''Subject to subparagraph (B), beginning January 1, 2016'' for ''Beginning January 1, 2016'', inserted ''(referred to in this subsection as the 'reporting period')'' after ''at a time specified by the Secretary'', and added subpar. (B).

Subsec. (a)(4). Pub. L. 116–94, §105(a)(1)(B), designated existing provisions as subpar. (A) and inserted heading, substituted ''Subject to subparagraph (B), in this section'' for ''In this section'', and added subpar. (B).

Subsec. (b)(3)(A). Pub. L. 116–94, §105(a)(2)(A), substituted ''through 2023'' for ''through 2022''.

Subsec. (b)(3)(B)(i). Pub. L. 116–94, §105(a)(2)(B)(i), substituted ''through 2020'' for ''through 2019''.

Subsec. (b)(3)(B)(ii). Pub. L. 116–94, §105(a)(2)(B)(ii), substituted ''2021 through 2023'' for ''2020 through 2022''.

Statutory Notes and Related Subsidiaries

MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS

Pub. L. 113–93, title II, §216(c)(2), Apr. 1, 2014, 128 Stat. 1061, provided that: ''The Inspector General of the Department of Health and Human Services shall—

''(A) publicly release an annual analysis of the top 25 laboratory tests by expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

''(B) conduct analyses the Inspector General determines appropriate with respect to the implementation and effect of the new payment system for laboratory tests under section 1834A of the Social Security Act [42 U.S.C. 1395m–1], as added by subsection (a).''

§ 1395n. Procedure for payment of claims of providers of services

(a) Conditions for payment for services described in section 1395k(a)(2) of this title

Except as provided in subsections (b), (c), and (e), payment for services described in section 1395k(a)(2) of this title furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc(a) of this title, and only if—

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

(2) a physician, or, in the case of services described in subparagraph (A), a physician, a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), (iii) such services are or were furnished while the individual is or was under the care of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), and (iv) in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary;

(B) in the case of medical and other health services, except services described in subparagraphs (B), (C), and (D) of section 1395x(s)(2) of this title, such services are or were medically required;

(C) in the case of outpatient physical therapy services or outpatient occupational therapy services, (i) such services are or were required because the individual needed physical therapy services or occupational therapy services, respectively, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically

reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(F) in the case of partial hospitalization services, (i) the individual would require inpatient psychiatric care in the absence of such services, (ii) an individualized, written plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

For purposes of this section, the term ''provider of services'' shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title) with respect to the furnishing of outpatient occupational therapy services or outpatient speech-language pathology services, respectively.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981 (or in the case of regulations to implement the amendments made by section 3708 of the CARES Act the Secretary shall prescribe regulations which shall become effective no later than 6 months after March 27, 2020), and which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019 or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,,[1] and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician, nurse practitioner, clinical nurse specialist, or physician assistant who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved. For purposes of paragraph (2)(A), an individual shall be considered to be ''confined to his home'' if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered ''confined to his home'', the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be ''confined to his home''. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the

[1] So in original.

Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Conditions for payment for services described in section 1395x(s) of this title

(1) Payment may also be made to any hospital for services described in section 1395x(s) of this title furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1395f(d)(1)(C) of this title with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1395*l*(a)(2) of this title and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1395cc(a) of this title.

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1395f(d)(1)(C) of this title, to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1395*l* of this title, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Collection of charges from individuals for services specified in section 1395x(s) of this title

Notwithstanding the provisions of this section and sections 1395k, 1395*l*, and 1395cc(a)(1)(A) of this title, a hospital or a critical access hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1395x(s) of this title and furnished to him by such hospital as an outpatient, but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1395*l*(a)(1) of this title. Payments under this subchapter to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position it would have been had it instead been reimbursed in accordance with section 1395*l*(a)(2) of this title (or, in the case of a critical access hospital, in accordance with section 1395*l*(a)(6) of this title).

(d) Payment to Federal provider of services or other Federal agencies prohibited

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

(e) Payment to fund designated by medical staff or faculty of medical school

For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1395x(b) of this title or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) of this title, and (2) for which the reasonable cost thereof is determined under section 1395x(v)(1)(D) of this title (or would be if section 1395ww of this title did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

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

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

(Aug. 14, 1935, ch. 531, title XVIII, § 1835, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 303; amended Pub. L. 90–248, title I, §§ 126(b), 129(c)(9)(A), (B), 130(a), (b), 133(e), Jan. 2, 1968, 81 Stat. 846, 848, 849, 851; Pub. L. 92–603, title II, §§ 204(b), 227(e)(2), 251(b)(2), 281(f), 283(b), Oct. 30, 1972, 86 Stat. 1377, 1406, 1445, 1456; Pub. L. 94–437, title IV, § 401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 96–499, title IX, §§ 930(e), (j), 933(b), 944(a), Dec. 5, 1980, 94 Stat. 2631, 2632, 2635, 2642; Pub. L. 97–35, title XXI, §§ 2106(b)(1), 2122(a)(1), Aug. 13, 1981, 95 Stat. 792, 796; Pub. L. 98–21, title VI, § 602(b), Apr. 20, 1983, 97 Stat. 163; Pub. L. 98–369, div. B, title III, §§ 2336(a), (b), 2342(b), 2354(b)(1), (8), (9), July 18, 1984, 98 Stat. 1091, 1094, 1100; Pub. L. 98–617, § 3(a)(3), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, § 9337(c), Oct. 21, 1986, 100 Stat. 2034; Pub. L. 100–203, title IV, §§ 4024(b), 4070(b)(3), 4085(i)(4), Dec. 22, 1987, 101 Stat. 1330–74, 1330–115, 1330–132; Pub. L. 100–360, title II, §§ 203(d)(1), 205(d), July 1, 1988, 102 Stat. 724, 731; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, § 6003(g)(3)(D)(viii), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 101–508, title IV, § 4008(m)(2)(D), Nov. 5, 1990, 104 Stat. 1388–53; Pub. L. 105–33, title IV, §§ 4201(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 475; Pub. L. 106–554, § 1(a)(6) [title V, § 507(a)(1)], Dec.

21, 2000, 114 Stat. 2763, 2763A–532; Pub. L. 108–173, title VII, § 736(c)(2)(B), Dec. 8, 2003, 117 Stat. 2356; Pub. L. 110–275, title I, § 143(b)(4), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title VI, §§ 6404(a)(2)(B), 6405(b)(2), 6407(a)(2), title X, §§ 10604, 10605(b), Mar. 23, 2010, 124 Stat. 768, 770, 1006; Pub. L. 115–123, div. E, title X, § 51002(b), Feb. 9, 2018, 132 Stat. 292; Pub. L. 116–136, div. A, title III, § 3708(b), Mar. 27, 2020, 134 Stat. 419.)

Editorial Notes

REFERENCES IN TEXT

The amendments made by section 3708 of the CARES Act, referred to in subsec. (a), are the amendments made by section 3708 of Pub. L. 116–136, which amended this section and sections 1395f, 1395x, and 1395ff of this title.

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–136, § 3708(b)(5), in fourth sentence of concluding provisions, inserted ''or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,'' after ''January 1, 2019'' and '', nurse practitioner, clinical nurse specialist, or physician assistant'' after ''of the physician''.

Pub. L. 116–136, § 3708(b)(4), in third sentence of concluding provisions, inserted '', nurse practitioner, clinical nurse specialist, or physician assistant'' after ''physician''.

Pub. L. 116–136, § 3708(b)(3), in second sentence of concluding provisions, substituted ''certification'' for ''physician certification'' and ''a physician, nurse practitioner, clinical nurse specialist, or physician assistant who'' for ''a physician who'' and inserted ''(or in the case of regulations to implement the amendments made by section 3708 of the CARES Act the Secretary shall prescribe regulations which shall become effective no later than 6 months after March 27, 2020)'' after ''1981''.

Pub. L. 116–136, § 3708(b)(2), in first sentence of concluding provisions, inserted '', nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be)'' after ''physician''.

Subsec. (a)(2). Pub. L. 116–136, § 3708(b)(1)(A), in introductory provisions, inserted '', a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is'' after ''in the case of services described in subparagraph (A), a physician''.

Subsec. (a)(2)(A)(ii), (iii). Pub. L. 116–136, § 3708(b)(1)(B)(i), inserted '', a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be)'' after ''physician''.

Subsec. (a)(2)(A)(iv). Pub. L. 116–136, § 3708(b)(1)(B)(ii), substituted ''made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter'' for ''after January 1, 2010, prior to making such certification the physician must document that the physician, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter''.

2018—Subsec. (a). Pub. L. 115–123 inserted ''For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved.'' before ''For purposes of paragraph (2)(A),'' in concluding provisions.

2010—Subsec. (a). Pub. L. 111–148, § 6404(a)(2)(B)(ii), inserted at end of concluding provisions ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

Subsec. (a)(1). Pub. L. 111–148, § 6404(a)(2)(B)(i), substituted ''period ending 1 calendar year after the date of service;'' for ''period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;''.

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

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

Pub. L. 111–148, § 6407(a)(2), added cl. (iv).

2008—Subsec. (a). Pub. L. 110–275, in second sentence, substituted ''subsection (g) or (*ll*)(2) of section 1395x of this title'' for ''section 1395x(g) of this title'' wherever appearing and inserted ''or outpatient speech-language pathology services, respectively'' before period at end.

2003—Subsec. (a). Pub. L. 108–173 substituted ''leave home and'' for ''leave home,'' in fifth sentence of concluding provisions.

2000—Subsec. (a). Pub. L. 106–554, in concluding provisions, struck out '', and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment'' after ''taxing effort by the individual'' and inserted at end ''Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be 'confined to his home'. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.''

1997—Subsec. (a)(2)(A). Pub. L. 105–33, § 4615(a), inserted ''(other than solely venipuncture for the purpose

of obtaining a blood sample)'' after ''skilled nursing care''.

Subsec. (c). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care'' in two places.

1990—Subsec. (c). Pub. L. 101–508 substituted ''a hospital or a rural primary care hospital may'' for ''a hospital may'' in first sentence, substituted ''section 1395*l*(a)(2) of this title (or, in the case of a rural primary care hospital, in accordance with section 1395*l*(a)(6) of this title)'' for ''section 1395*l*(a)(2) of this title'' in second sentence, and struck out at end ''A rural primary care hospital shall be considered a hospital for purposes of this subsection.''

1989—Subsec. (a)(2)(G), (H). Pub. L. 101–234 repealed Pub. L. 100–360, §§ 203(d)(1), 205(d), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (c). Pub. L. 101–239 inserted at end ''A rural primary care hospital shall be considered a hospital for purposes of this subsection.''

1988—Subsec. (a)(2)(G). Pub. L. 100–360, § 203(d)(1), added subpar. (G) relating to home intravenous drug therapy services.

Subsec. (a)(2)(H). Pub. L. 100–360, § 205(d), added subpar. (H) relating to in-home care provided to chronically dependent individuals.

1987—Subsec. (a). Pub. L. 100–203, § 4024(b), inserted two sentences at end clarifying ''confined to his home'' for purposes of par. (2)(A).

Subsec. (a)(2)(C)(i). Pub. L. 100–203, § 4085(i)(4), struck out second comma at end.

Subsec. (a)(2)(F). Pub. L. 100–203, § 4070(b)(3), added subpar. (F).

1986—Subsec. (a). Pub. L. 99–509, § 9337(c)(2), inserted in second sentence ''(or meets the requirements of such section through the operation of section 1395x(g) of this title)'' in two places, and ''or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services''.

Subsec. (a)(2)(C). Pub. L. 99–509, § 9337(c)(1), inserted ''or outpatient occupational therapy services'' in introductory provisions, ''or occupational therapy services, respectively,'' in cl. (i), and ''or qualified occupational therapist, respectively,'' in cl. (ii).

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

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

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

Subsec. (a)(2)(B), (C). Pub. L. 98–369, § 2354(b)(8)(A), struck out ''and'' at end.

Subsec. (a)(2)(C)(ii). Pub. L. 98–369, § 2342(b), substituted ''by a physician or by the qualified physical therapist providing such services and is periodically reviewed by a physician'' for '', and is periodically reviewed, by a physician''.

Subsec. (a)(2)(D). Pub. L. 98–369, § 2354(b)(8)(B), realigned margin of subpar. (D).

Subsec. (e)(2). Pub. L. 98–369, § 2354(b)(9), designated concluding pars. (1) and (2) as (A) and (B), respectively, and in par. (B) inserted ''(i)'' after ''written assurances that'' and substituted ''(ii) the individuals who'' for ''(B) the individuals who'' and ''return of'' for ''return for''.

1983—Subsec. (e). Pub. L. 98–21 inserted ''(or would be if section 1395ww of this title did not apply)'' after ''section 1395(v)(1)(D) of this title''.

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

Subsec. (a)(2)(D). Pub. L. 97–35, § 2106(b)(1), inserted ''and'' after ''physician;''.

Subsec. (a)(2)(E). Pub. L. 97–35, § 2106(b)(1), substituted a period for ''; and'' at the end.

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

Subsec. (a)(2)(A). Pub. L. 96–499, § 930(j), substituted ''physical, occupational, or speech'' for ''physical or speech''.

Subsec. (a)(2)(D)(ii). Pub. L. 96–499, § 944(a), inserted ''by a physician or by the speech pathologist providing such services'', after ''has been established''.

Subsec. (a)(2)(E). Pub. L. 96–499, § 933(b), added subpar. (E).

1976—Subsec. (d). Pub. L. 94–437 substituted ''Subject to section 1395qq of this title, no payment'' for ''No payment''.

1972—Subsec. (a). Pub. L. 92–603, § 227(e)(2)(A), inserted reference to subsec. (e) of this section in introductory provisions.

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

Subsec. (a)(2)(C). Pub. L. 92–603, § 251(b)(2), substituted ''because the individual needed physical therapy services'' for ''because the individual needed physical therapy services on an outpatient basis''.

Subsec. (a)(2)(D). Pub. L. 92–603, § 283(b), added subpar. (D).

Subsec. (c). Pub. L. 92–603, § 204(b), substituted ''the applicable supplementary medical insurance deductible'' for ''$50''.

Subsec. (e). Pub. L. 92–603, § 227(e)(2)(B), added subsec. (e).

1968—Subsec. (a). Pub. L. 90–248, §§ 129(c)(9)(A), 130(a), inserted introductory exception phrase and included reference to subsec. (c).

Subsec. (a)(2). Pub. L. 90–248, § 133(e)(5), inserted sentence at end defining ''provider of services''.

Subsec. (a)(2)(B). Pub. L. 90–248, §§ 126(b), 133(e)(4), inserted ''except services described in subparagraphs (B) and (C) of section 1395x(s)(2) of this title,'' after ''health services,'' and inserted reference to subpar. (d).

Subsec. (a)(2)(C). Pub. L. 90–248, § 133(e)(1)–(3), added subpar. (C).

Subsec. (b). Pub. L. 90–248, § 129(c)(9)(B), added subsec. (b). Former subsec. (b) redesignated (c), in turn redesignated (d).

Subsec. (c). Pub. L. 90–248, § 130(b), added subsec. (c). Former subsec. (c), previously designated (b), redesignated (d).

Subsec. (d). Pub. L. 90–248, §§ 129(c)(9)(B), 130(b), redesignated former subsec. (b) as (c), in turn as (d), respectively.

Statutory Notes and Related Subsidiaries

Effective Date of 2020 Amendment

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395f of this title.

Effective Date of 2010 Amendment

Amendment by section 6404(a)(2)(B) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2010,

and in case of services furnished before Jan. 1, 2010, a bill or request for payment under 42 U.S.C. 1395n(a) to be filed not later than Dec. 31, 2010, see section 6404(b) of Pub. L. 111–148, set out as a note under section 1395f of this title.

Amendment by section 6405(b)(2) of Pub. L. 111–148 applicable to written orders and certifications made on or after July 1, 2010, see section 6405(d) of Pub. L. 111–148, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to home health services furnished on or after Dec. 21, 2000, see section 1(a)(6) [title V, §507(a)(2)] of Pub. L. 106–554, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

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

Amendment by section 4615(a) of Pub. L. 105–33 applicable to home health services furnished after 6-month period beginning after Aug. 5, 1997, see section 4615(b) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(d)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 205(d) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4024(b) of Pub. L. 100–203 applicable to items and services provided on or after Jan. 1, 1988, see section 4024(c) of Pub. L. 100–203, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2336(a) of Pub. L. 98–369 applicable to certifications and plans of care made or established on or after July 18, 1984, see section 2336(c)(1) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2342(c), July 18, 1984, 98 Stat. 1094, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] apply to plans of care established on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(1), (8), (9) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2122(a)(1) of Pub. L. 97–35 applicable to services furnished pursuant to plans of treatment implemented after the third month beginning after Aug. 13, 1981, see section 2122(b) of Pub. L. 97–35, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

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

Amendment by section 933(b) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

Pub. L. 96–499, title IX, §944(b), Dec. 5, 1980, 94 Stat. 2642, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plans for furnishing services established on or after January 1, 1981.''

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 204(b) of Pub. L. 92–603 effective with respect to calendar years after 1972, see section 204(c) of Pub. L. 92–603, set out as a note under section 1395*l* of this title.

Amendment by section 227(e)(2) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 251(b)(2) of Pub. L. 92–603 applicable with respect to services furnished on or after Oct. 30, 1972, see section 251(d)(2) of Pub. L. 92–603, set out as a note under section 1395x of this title.

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

Pub. L. 92–603, title II, §283(c), Oct. 30, 1972, 86 Stat. 1456, provided that: ''The provisions of this section [amending this section and section 1395x of this title] shall apply with respect to services rendered after December 31, 1972.''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 126(b) of Pub. L. 90–248 applicable with respect to services furnished after Jan. 2, 1968, see section 126(c) of Pub. L. 90–248, set out as a note under section 1395f of this title.

Amendment by section 129(c)(9)(A), (B) of Pub. L. 90–248 applicable with respect to services furnished after March 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §130(c), Jan. 2, 1968, 81 Stat. 849, provided that: ''The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968.''

Amendment by section 133(e) of Pub. L. 90–248 applicable with respect to services furnished after June 30,

1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

REGULATIONS

Secretary of Health and Human Services required to provide, not later than 90 days after July 18, 1984, for revision of regulations as may be required to reflect amendment to subsec. (a) by section 2336(b) of Pub. L. 98–369, see section 2336(c)(2) of Pub. L. 98–369, set out as a note under section 1395f of this title.

MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES

Pub. L. 108–173, title VI, § 647, Dec. 8, 2003, 117 Stat. 2326, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

''(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

''(c) DIRECT ACCESS DEFINED.—The term 'direct access' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

''(1) without regard to any requirement that—

''(A) an individual be under the care of (or referred by) a physician; or

''(B) services be provided under the supervision of a physician; and

''(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

''(A) certification and recertification; and

''(B) establishment and periodic review of a plan of care.''

HOME HEALTH PROSPECTIVE PAYMENT DEMONSTRATION PROJECT

Pub. L. 100–203, title IV, § 4027, Dec. 22, 1987, 101 Stat. 1330–75, as amended by Pub. L. 100–360, title IV, § 411(d)(6), July 1, 1988, 102 Stat. 775, directed Secretary of Health and Human Services to provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the medicare and medicaid programs, directed that the project be designed in a manner to enable the Secretary to evaluate the effects of various methods of prospective payment (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, access to, and quality of, home health care, and home health agency operations, directed Secretary to assure that services are first furnished under the project not later than Apr. 1, 1989, and, for this purpose, authorized Secretary to reinstate a previously awarded contract, or award a sole source contract, to carry out the project, provided for funding, and directed Secretary to submit to Congress, not later than one year after Dec. 22, 1987, an interim report on the demonstration project and, not later than four years after Dec. 22, 1987, a final report on results of the project.

§ 1395*o*. Eligible individuals

(a) In general

Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

(b) Individuals eligible for immunosuppressive drug coverage

(1) In general

Except as provided under paragraph (2), every individual whose entitlement to insurance benefits under part A ends (whether before, on, or after January 1, 2023) by reason of section 426–1(b)(2) of this title is eligible to enroll or to be deemed to have enrolled in the medical insurance program established by this part solely for purposes of coverage of immunosuppressive drugs in accordance with section 1395p(n) of this title.

(2) Exception if other coverage is available

(A) In general

An individual described in paragraph (1) shall not be eligible for enrollment in the program for purposes of coverage described in such paragraph with respect to any period in which the individual, as determined in accordance with subparagraph (B)—

(i) is enrolled in a group health plan or group or individual health insurance coverage, as such terms are defined in section 300gg–91 of this title;

(ii) is enrolled for coverage under the TRICARE for Life program under section 1086(d) of title 10;

(iii) is enrolled under a State plan (or waiver of such plan) under subchapter XIX and is eligible to receive benefits for immunosuppressive drugs described in this subsection under such plan (or such waiver);

(iv) is enrolled under a State child health plan (or waiver of such plan) under subchapter XXI and is eligible to receive benefits for such drugs under such plan (or such waiver); or

(v)(I) is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38;

(II) is not required to enroll under section 1705 of such title to receive immunosuppressive drugs described in this subsection; or

(III) is otherwise eligible under a provision of title 38, other than section 1710 of such title to receive immunosuppressive drugs described in this subsection.

(B) Eligibility determinations

(i) In general

The Secretary, in coordination with the Commissioner of Social Security, shall establish a process for determining whether an individual described in paragraph (1)

who is to be enrolled or deemed to be enrolled in the medical insurance program described in such paragraph meets the requirements for such enrollment under this subsection, including the requirement that the individual not be enrolled in other coverage as described in subparagraph (A).

(ii) Attestation regarding other coverage

The process established under clause (i) shall include, at a minimum, a requirement that—

(I) the individual provide to the Commissioner an attestation that the individual is not enrolled and does not expect to enroll in such other coverage; and

(II) the individual notify the Commissioner within 60 days of enrollment in such other coverage.

(Aug. 14, 1935, ch. 531, title XVIII, § 1836, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 304; amended Pub. L. 92–603, title II, § 201(c)(1), Oct. 30, 1972, 86 Stat. 1372; Pub. L. 116–260, div. CC, title IV, § 402(a)(2)(A), Dec. 27, 2020, 134 Stat. 2998.)

Editorial Notes

AMENDMENTS

2020—Pub. L. 116–260 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

1972—Pub. L. 92–603 designed former par. (2)(B) as par. (1), former par. (1) as introductory clause in par. (2), and former pars. (2)(A)(i) and (ii) as pars. (2)(A) and (B), and struck out ''(A)'' after ''(2)''.

Statutory Notes and Related Subsidiaries

PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Pub. L. 89–97, title I, § 104(b)(2), July 30, 1965, 79 Stat. 334, provided that: ''An individual who has been convicted of any offense under (A) chapter 37 [section 792 et seq. of Title 18, Crimes and Criminal Procedure] (relating to espionage and censorship), chapter 105 [section 2151 et seq. of Title 18] (relating to sabotage), or chapter 115 [section 2381 et seq. of Title 18] (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended [section 783, 822, or 823 of Title 50, War and National Defense], may not enroll under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].''

§ 1395p. Enrollment periods

(a) Generally; regulations

An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) Repealed. Pub. L. 96–499, title IX, § 945(a), Dec. 5, 1980, 94 Stat. 2642

(c) Initial general enrollment period; eligible individuals before March 1, 1966

In the case of individuals who first satisfy paragraph (1) or (2) of section 1395*o*(a) of this title before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after July 30, 1965, and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1395*o*(a) of this title but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) Eligible individuals on or after March 1, 1966

In the case of an individual who first satisfies paragraph (1) or (2) of section 1395*o*(a) of this title on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1395q of this title as though he had attained such age at that time).

(e) General enrollment period

There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Individuals deemed enrolled in medical insurance program

Any individual—

(1) who is eligible under section 1395*o*(a) of this title to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) Commencement of enrollment period

All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 426(b) of this title, his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1395r(d) of this title) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 402 or 423 of this title on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 402 of this title during the first 3 months of such period, his enrollment shall be deemed to have occurred

in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 402 of this title on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction

In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1395i–2 of this title is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(i) Special enrollment periods

(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1395*o*(a) of this title, is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1395*o*(a) of this title, is enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A);

(B) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or individual's spouse's) current employment status; and

(C) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment status,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of current employment status ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 426(b) of this title and—

(i) who at the time the individual first satisfies paragraph (1) of section 1395*o*(a) of this title—

(I) is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's current or

former employment or by reason of the current or former employment status of a member of the individual's family, and

(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).

(j) Special rules for individuals with ALS

In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 426(h) of this title, the following special rules apply:

(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1395*o*(a)(1) of this title.

(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.

(k) Special enrollment period for certain volunteers serving outside United States

(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1395*o*(a) of this title, is described in paragraph (3), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; or

(B) has terminated enrollment under this section during a month in which the individual is described in paragraph (3),

there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph is the 6-month period beginning on the first day of the month which includes the date that the individual is no longer described in paragraph (3).

(3) For purposes of paragraph (1), an individual described in this paragraph is an individual who—

(A) is serving as a volunteer outside of the United States through a program—

(i) that covers at least a 12-month period; and

(ii) that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

(B) demonstrates health insurance coverage while serving in the program.

***(l)* Special enrollment period for disabled TRICARE beneficiaries**

(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10) at the time the individual is entitled to part A under section 426(b) of this title or section 426–1 of this title and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10.

(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.

(m) Special enrollment periods for exceptional circumstances

Beginning January 1, 2023, the Secretary may establish special enrollment periods in the case of individuals who satisfy paragraph (1) or (2) of section 1395*o*(a) of this title and meet such exceptional conditions as the Secretary may provide.

(n) Enrollment for individuals only eligible for coverage of immunosuppressive drugs

(1) Any individual who is eligible for coverage of immunosuppressive drugs under section 1395*o*(b) of this title may enroll or be deemed to have enrolled only in such manner and form as may be prescribed by regulations, and only during an enrollment period described in this subsection.

(2) An individual described in paragraph (1) whose entitlement for hospital insurance bene-

fits under part A ends by reason of section 426–1(b)(2) of this title prior to January 1, 2023, may enroll beginning on October 1, 2022, or the day on which the individual first satisfies section 1395*o*(b) of this title, whichever is later.

(3) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 426–1(b)(2) of this title on or after January 1, 2023, shall be deemed to have enrolled in the medical insurance program established by this part for purposes of coverage of immunosuppressive drugs.

(4) The Secretary shall establish a process under which an individual described in paragraph (1) whose other coverage described in section 1395*o*(b)(2)(A) of this title, or coverage under this part (including the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs), is terminated voluntarily or involuntary[1] may enroll or reenroll, if applicable, in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

(Aug. 14, 1935, ch. 531, title XVIII, § 1837, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 304; amended Pub. L. 89–384, § 3(a), (b), Apr. 8, 1966, 80 Stat. 105; Pub. L. 90–248, title I, §§ 136(a), 145(a), (b), Jan. 2, 1968, 81 Stat. 853, 859; Pub. L. 92–603, title II, §§ 201(c)(2), 206(a), 259(a), 260, Oct. 30, 1972, 86 Stat. 1372, 1378, 1448; Pub. L. 96–265, title I, § 103(a)(3), June 9, 1980, 94 Stat. 444; Pub. L. 96–499, title IX, § 945(a), (b), Dec. 5, 1980, 94 Stat. 2642; Pub. L. 97–35, title XXI, § 2151(a)(1), (2), Aug. 13, 1981, 95 Stat. 801; Pub. L. 98–369, div. B, title III, §§ 2338(b), 2354(b)(10), July 18, 1984, 98 Stat. 1092, 1101; Pub. L. 99–272, title IX, §§ 9201(c)(1), 9219(a)(2), Apr. 7, 1986, 100 Stat. 171, 182; Pub. L. 99–509, title IX, § 9319(c)(1)–(3), Oct. 21, 1986, 100 Stat. 2011; Pub. L. 99–514, title XVIII, § 1895(b)(12), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 101–239, title VI, § 6202(b)(4)(C), (c)(1), Dec. 19, 1989, 103 Stat. 2233; Pub. L. 103–432, title I, §§ 147(f)(1)(A), 151(c)(2), Oct. 31, 1994, 108 Stat. 4430, 4435; Pub. L. 105–33, title IV, §§ 4581(b)(1), 4631(a)(2), Aug. 5, 1997, 111 Stat. 465, 486; Pub. L. 106–554, § 1(a)(6) [title I, § 115(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474; Pub. L. 109–171, title V, § 5115(a)(2)(A), Feb. 8, 2006, 120 Stat. 45; Pub. L. 111–148, title III, § 3110(a)(1), Mar. 23, 2010, 124 Stat. 420; Pub. L. 116–260, div. CC, title I, § 120(a)(2)(A), title IV, § 402(a)(2)(B), (b), Dec. 27, 2020, 134 Stat. 2954, 2999.)

Editorial Notes

References in Text

Section 501 of the Internal Revenue Code of 1986, referred to in subsec. (k)(3)(A)(ii), is classified to section 501 of Title 26, Internal Revenue Code.

Amendments

2020—Pub. L. 116–260, § 402(a)(2)(B)(i), substituted ''section 1395*o*(a) of this title'' for ''section 1395*o* of this title'' wherever appearing except in subsec. (m).

Subsec. (j)(1). Pub. L. 116–260, § 402(a)(2)(B)(ii), substituted ''section 1395*o*(a)(1) of this title'' for ''section 1395*o*(1) of this title''.

Subsec. (m). Pub. L. 116–260, § 120(a)(2)(A), added subsec. (m).

Subsec. (n). Pub. L. 116–260, § 402(b), added subsec. (n).

2010—Subsec. (*l*). Pub. L. 111–148 added subsec. (*l*).

2006—Subsec. (k). Pub. L. 109–171 added subsec. (k).

2000—Subsec. (j). Pub. L. 106–554 added subsec. (j).

1997—Subsec. (i)(1) to (3). Pub. L. 105–33, § 4631(a)(2), substituted ''1395y(b)(1)(B)(iii) of this title'' for ''1395y(b)(1)(B)(iv) of this title'' wherever appearing.

Subsec. (i)(4). Pub. L. 105–33, § 4581(b)(1), added par. (4).

1994—Subsec. (i)(1). Pub. L. 103–432, § 151(c)(2)(A), in closing provisions substituted ''(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)'' for ''as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)''.

Subsec. (i)(1)(A). Pub. L. 103–432, § 151(c)(2)(D), inserted ''status'' after ''current employment''.

Subsec. (i)(2). Pub. L. 103–432, § 151(c)(2)(A), (C), in closing provisions substituted ''(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)'' for ''as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)'' and ''by reason of the individual's current employment status (or the current employment status of a family member of the individual)'' for ''as an active individual''.

Subsec. (i)(2)(B), (C). Pub. L. 103–432, § 151(c)(2)(D), inserted ''status'' after ''current employment''.

Subsec. (i)(3)(A). Pub. L. 103–432, § 151(c)(2)(D), inserted ''status'' after ''current employment''.

Pub. L. 103–432, § 147(f)(1)(A), substituted ''including each month during any part of which the individual is enrolled'' for ''beginning with the first day of the first month in which the individual is no longer enrolled'' and ''ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled'' for ''and ending seven months later''.

Subsec. (i)(3)(B). Pub. L. 103–432, § 151(c)(2)(B), substituted ''in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)'' for ''as an active individual in a large group health plan (as such terms are defined in section 1395y(b)(1)(B)(iv) of this title)''.

Pub. L. 103–432, § 147(f)(1)(A), substituted ''including each month during any part of which the individual is enrolled'' for ''beginning with the first day of the first month in which the individual is no longer enrolled'' and ''ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled'' for ''and ending seven months later''.

1989—Subsec. (i)(1). Pub. L. 101–239, § 6202(c)(1)(A), redesignated subpars. (B) and (C) as (A) and (B), respectively, struck out former subpar. (A) which read as follows: ''has attained the age of 65,'', and inserted ''not described in the previous sentence'' after ''In the case of an individual'' in second sentence.

Pub. L. 101–239, § 6202(b)(4)(C), substituted ''section 1395y(b)(1)(A)(v)'' and ''section 1395y(b)(1)(B)(iv)'' for ''section 1395y(b)(3)(A)(iv)'' and ''section 1395y(b)(4)(B)'', respectively.

Subsec. (i)(2). Pub. L. 101–239, § 6202(c)(1)(B), substituted ''(1)(A)'' for ''(1)(B)'' in subpar. (B)(i), redesignated subpars. (B) and (C) as (A) and (B), respectively, struck out former subpar. (A) which read as follows: ''has attained the age of 65;'', and inserted ''not described in the previous sentence'' after ''In the case of an individual'' in second sentence.

Pub. L. 101–239, § 6202(b)(4)(C), substituted ''section 1395y(b)(1)(A)(v)'' and ''section 1395y(b)(1)(B)(iv)'' for ''section 1395y(b)(3)(A)(iv)'' and ''section 1395y(b)(4)(B)'', respectively.

Subsec. (i)(3). Pub. L. 101–239, § 6202(b)(4)(C), substituted ''section 1395y(b)(1)(A)(v)'' and ''section

[1] So in original. Probably should be ''involuntarily''.

1395y(b)(1)(B)(iv)'' for ''section 1395y(b)(3)(A)(iv)'' and ''section 1395y(b)(4)(B)'', respectively.

1986—Subsec. (i)(1). Pub. L. 99–509, §9319(c)(1), inserted sentence at end providing for a special enrollment period described in paragraph (3)(B) for individuals not age 65, enrolled in a large health plan, and having elected not to enroll during initial enrollment period.

Subsec. (i)(1)(A). Pub. L. 99–514 realigned margins of subpar. (A).

Pub. L. 99–272, §9219(a)(2)(A), amended subpar. (A) generally, substituting ''has attained the age of 65'' for ''meets the conditions described in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title''.

Subsec. (i)(2). Pub. L. 99–509, §9319(c)(2), inserted sentence at end providing for a special enrollment period described in paragraph (3)(B) for individuals not age 65, enrolled or deemed enrolled in the medical insurance program established under this part, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during a subsequent special enrollment period during which the individual was not enrolled in a large group health plan, and has not terminated enrollment.

Subsec. (i)(2)(A). Pub. L. 99–272, §9219(a)(2)(B), amended subpar. (A) generally, substituting ''has attained the age of 65;'' for ''meets the conditions described in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title,''.

Subsec. (i)(2)(B). Pub. L. 99–272, §9219(a)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period and any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1395y(b)(3)(A)(iv) of this title by reason of the individual's (or individual's spouse's) current employment, and''.

Subsec. (i)(2)(C), (D). Pub. L. 99–272, §9219(a)(2)(B), added subpar. (C) and redesignated former subpar. (C) as (D).

Subsec. (i)(3). Pub. L. 99–509, §9319(c)(3), designated existing provisions as subpar. (A), inserted ''the first sentences of'' after ''referred to in'', and added subpar. (B).

Pub. L. 99–272, §9201(c)(1), amended par. (3) generally, striking out provision that special enrollment period could be period beginning with first day of third month before month in which the individual attains age of 70 and ending seven months later.

1984—Subsec. (g)(1). Pub. L. 98–369, §2354(b)(10), substituted ''section 426(b) of this title'' for ''section 426(a)(2)(B) of this title'' and ''section 1395r(d) of this title'' for ''section 1395(e) of this title''.

Subsec. (i). Pub. L. 98–369, §2338(b), added subsec. (i).

1981—Subsec. (e). Pub. L. 97–35, §2151(a)(1), substituted ''during the period beginning on January 1 and ending on March 31 of each year'' for ''which is any period after the period described in subsection (d) of this section''.

Subsec. (g)(3). Pub. L. 97–35, §2151(a)(2), substituted ''the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)'' for ''the month in which the individual files an application establishing such entitlement''.

1980—Subsec. (b). Pub. L. 96–499, §945(a), struck out subsec. (b) which provided that no individual could enroll under this part more than twice.

Subsec. (e). Pub. L. 96–499, §945(b)(1), substituted ''which is any period after the period described in subsection (d) of this section'' for '', after the period described in subsection (c) of this section, during the period beginning on January 1 and ending on March 31 of each year beginning with 1969''.

Subsec. (g)(1). Pub. L. 96–265 substituted ''the 25th month'' for ''the 25th consecutive month''.

Subsec. (g)(3). Pub. L. 96–499, §945(b)(2), substituted ''the month in which the individual files an application establishing such entitlement'' for ''the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)''.

1972—Subsec. (b). Pub. L. 92–603, §260, struck out provisions preventing enrollment under this part more than three years after first opportunity for such enrollment.

Subsec. (c). Pub. L. 92–603, §201(c)(2)(A), (B), substituted ''paragraph (1) or (2)'' for ''paragraphs (1) and (2)'', and substituted provisions relating to the treatment of an individual who has attained age 65 and who satisfies paragraph (1) of section 1395*o* of this title but not paragraph (2) of such section, for provisions relating to the treatment of an individual who satisfies paragraph (2) of section 1395*o* of this title solely by reason of subparagraph (B) thereof.

Subsec. (d). Pub. L. 92–603, §201(c)(2)(C), substituted ''paragraph (1) or (2)'' for ''paragraphs (1) and (2)''.

Subsecs. (f), (g). Pub. L. 92–603, §206(a), added subsecs. (f) and (g).

Subsec. (h). Pub. L. 92–603, §259(a), added subsec. (h).

1968—Subsec. (b)(1). Pub. L. 90–248, §145(a), permitted an individual enrolling in supplementary medical insurance program for first time to enroll at any time in a general enrollment period which begins within 3 years of close of his initial enrollment period.

Subsec. (d). Pub. L. 90–248, §136(a), inserted last sentence providing that if an individual who has attained age 65 failed to enroll in program because, relying on erroneous documentary evidence, he was mistaken about his age, he may enroll using date of attainment of age 65 that he alleges under documentary evidence.

Subsec. (e). Pub. L. 90–248, §145(b), provided for an annual general enrollment period for supplementary medical insurance program beginning January 1 and ending March 31 of each year, commencing in 1969.

1966—Subsec. (c). Pub. L. 89–384, §3(a), delayed eligibility date from January 1, 1966, to March 1, 1966, and closing date for enrollment period from March 31, 1966, to May 31, 1966.

Subsec. (d). Pub. L. 89–384, §3(b), substituted March 1, 1966, for January 1, 1966.

Statutory Notes and Related Subsidiaries

Effective Date of 2010 Amendment

Pub. L. 111–148, title III, §3110(a)(2), Mar. 23, 2010, 124 Stat. 420, as amended by Pub. L. 111–309, title II, §201, Dec. 15, 2010, 124 Stat. 3289, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to elections made on and after the date of the enactment of this Act [Mar. 23, 2010].''

[Pub. L. 111–309, title II, §201, Dec. 15, 2010, 124 Stat. 3289, provided that the amendment made by section 201 to section 3110(a)(2) of Pub. L. 111–148, set out above, is effective as if included in the enactment of Pub. L. 111–148.]

Effective Date of 2006 Amendment

Pub. L. 109–171, title V, §5115(b), Feb. 8, 2006, 120 Stat. 46, provided that: ''The amendment made by subsection (a)(1) [amending section 1395r of this title] shall apply to months beginning with January 2007 and the amendments made by subsection (a)(2) [amending this section and section 1395q of this title] shall take effect on January 1, 2007.''

Effective Date of 2000 Amendment

Amendment by Pub. L. 106–554 applicable to benefits for months beginning July 1, 2001, see section 1(a)(6) [title I, §115(c)] of Pub. L. 106–554, set out as a note under section 426 of this title.

Effective Date of 1997 Amendment

Pub. L. 105–33, title IV, §4581(c), Aug. 5, 1997, 111 Stat. 465, provided that: ''The amendments made by this section [amending this section and sections 1395q and 1395r of this title] shall apply to involuntary terminations of

coverage under a group health plan occurring on or after the date of the enactment of this Act [Aug. 5, 1997].''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 147(f)(1)(C), Oct. 31, 1994, 108 Stat. 4431, provided that: ''The amendments made by subparagraphs (A) and (B) [amending this section and section 1395q of this title] shall take effect on the first day of the first month that begins after the expiration of the 120-day period that begins on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, § 151(c)(2), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6202(b)(4)(C) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 101–239, title VI, § 6202(c)(3), Dec. 19, 1989, 103 Stat. 2234, provided that: ''The amendments made by this subsection [amending this section and section 1395r of this title] shall apply to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after the date of the enactment of this Act [Dec. 19, 1989].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 99–509 applicable to enrollments occurring on or after Jan. 1, 1987, see section 9319(f)(2) of Pub. L. 99–509, set out as a note under section 1395y of this title.

Pub. L. 99–272, title IX, § 9201(d)(2), Apr. 7, 1986, 100 Stat. 171, provided that: ''The amendments made by subsections (b) and (c) [amending this section, section 1395q of this title, and sections 623 and 631 of Title 29, Labor] shall become effective on May 1, 1986.''

Pub. L. 99–272, title IX, § 9219(a)(3)(B), Apr. 7, 1986, 100 Stat. 182, provided that:

''(i) The amendments made by paragraph (2) [amending this section] shall apply to enrollments in months beginning with the first effective month (as defined in clause (ii)), except that in the case of any individual who would have a special enrollment period under section 1837(i) of the Social Security Act [42 U.S.C. 1395p(i)] that would have begun after November 1984 and before the first effective month, the period shall be deemed to begin with the first day of the first effective month.

''(ii) For purposes of clause (i), the term 'first effective month' means the first month that begins more than 90 days after the date of the enactment of this Act [Apr. 7, 1986].''

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2338(d)(2), July 18, 1984, 98 Stat. 1093, provided that:

''(A) The amendments made by subsections (b) and (c) [amending this section and section 1395q of this title] shall apply to enrollments in months beginning with the first effective month, except that in the case of any individual who would have had a special enrollment period under section 1837(i) of the Social Security Act [42 U.S.C. 1395p(i)] that would have begun before such first effective month, such period shall be deemed to begin with the first day of such first effective month.

''(B) For purposes of subparagraph (A), the term 'first effective month' means the first month which begins more than 90 days after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(10) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, § 2151(b), Aug. 13, 1981, 95 Stat. 802, provided that: ''The amendments made by this section [amending this section and sections 1395q and 1395r of this title] shall not apply to enrollments pursuant to written requests for enrollment filed before October 1, 1981.''

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, § 945(d), Dec. 5, 1980, 94 Stat. 2642, provided that: ''The amendments made by subsections (a), (b), and (c) [amending this section and sections 1395q and 1395r of this title] shall apply to enrollments occurring on or after April 1, 1981.''

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

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 259(b), Oct. 30, 1972, 86 Stat. 1448, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective as of July 1, 1966.''

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, § 136(b), Jan. 2, 1968, 81 Stat. 853, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to individuals enrolling under part B of title XVIII [42 U.S.C. 1395j et seq.] in months beginning after the date of the enactment of this Act [Jan. 2, 1968].''

Pub. L. 90–248, title I, § 145(e), Jan. 2, 1968, 81 Stat. 859, provided that: ''The amendments made by subsections (a), (b), and (c) [amending this section and section 1395q of this title] shall become effective April 1, 1968. Notwithstanding the provisions of section 2 of Public Law 90–97, the amendments made by subsection (d) [amending section 1395r of this title] shall become effective December 1, 1968.''

MEDICARE PART B SPECIAL ENROLLMENT PERIOD

Pub. L. 108–173, title VI, § 625(b), Dec. 8, 2003, 117 Stat. 2318, provided that:

''(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act [Dec. 8, 2003], is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

''(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall begin on the first day of the month following the month in which the individual enrolls.''

EXTENSION THROUGH MARCH 31, 1968 OF 1967 GENERAL ENROLLMENT PERIOD

Pub. L. 90–97, § 1, Sept. 30, 1967, 81 Stat. 249, extended the general enrollment period under subsec. (e) of this section, beginning Oct. 1, 1967, and ending Dec. 31, 1967,

for purposes of enrolling in the insurance program established under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] and of terminating such enrollment as provided in section 1395q(b)(1) of this title, through Mar. 31, 1968.

ENROLLMENT BEFORE OCT. 1, 1966, OF ELIGIBLE INDIVIDUALS FAILING FOR GOOD CAUSE TO ENROLL BEFORE JUNE 1, 1966; COMMENCEMENT OF COVERAGE PERIOD

Pub. L. 89–97, title I, § 102(b), July 30, 1965, 79 Stat. 332, as amended by Pub. L. 89–384, § 3(c), Apr. 8, 1966, 80 Stat. 105, provided that: ''If—

''(1) an individual was eligible to enroll under section 1837(c) of the Social Security Act [42 U.S.C. 1395p(c)] before June 1, 1966, but failed to enroll before such date, and

''(2) it is shown to the satisfaction of the Secretary of Health, Education, and Welfare [now Health and Human Services] that there was good cause for such failure to enroll before June 1, 1966,

such individual may enroll pursuant to this subsection at any time before October 1, 1966. The determination of what constitutes good cause for purposes of the preceding sentence shall be made in accordance with regulations of the Secretary. In the case of any individual who enrolls pursuant to this subsection, the coverage period (within the meaning of section 1838 of the Social Security Act [42 U.S.C. 1395q]) shall begin on the first day of the 6th month after the month in which he enrolls.''

§ 1395q. Coverage period

(a) Commencement

The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his ''coverage period'') shall begin on whichever of the following is the latest:

(1) July 1, 1966, or (in the case of a disabled individual who has not attained age 65) July 1, 1973; or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1395p of this title before the month in which he first satisfies paragraph (1) or (2) of section 1395*o*(a) of this title, the first day of such month,

(B) in the case of an individual who first satisfies such paragraph in a month beginning before January 2023 and who enrolls pursuant to such subsection (d)—

(i) in such month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls,

(ii) in the month following such month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(iii) more than one month following such month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls,

(C) in the case of an individual who first satisfies such paragraph in a month beginning on or after January 1, 2023, and who enrolls pursuant to such subsection (d) in such month in which he first satisfies such paragraph or in any subsequent month of his initial enrollment period, the first day of the month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to subsection (e) of section 1395p of this title in a month beginning—

(i) before January 1, 2023, the July 1 following the month in which he so enrolls; or

(ii) on or after January 1, 2023, the first day of the month following the month in which he so enrolls; or

(3) in the case of an individual who is deemed to have enrolled—

(A) on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1395*o*(a) of this title or July 1, 1973, whichever is later, or

(B) on or after the first day of the fourth month of his initial enrollment period, and where such month begins—

(i) before January 1, 2023, as prescribed under subparagraphs (B)(i), (B)(ii), (B)(iii), and (D)(i) of paragraph (2), or

(ii) on or after January 1, 2023, as prescribed under subparagraphs (C) and (D)(ii) of paragraph (2).

(b) Continuation

An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1395v(e) of this title) take effect at the close of the month following the month in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1395p(f) of this title or section 1395p(n)(3) of this title files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1395p(f) of this title or section 1395p(n)(3) of this title files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the month following the month in which the notice is filed.

(c) Termination

In the case of an individual satisfying paragraph (1) of section 1395*o*(a) of this title whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage pe-

riod (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) Payment of expenses incurred during coverage period

No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

(e) Commencement of coverage for special enrollment periods

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(i)(3) or 1395p(i)(4)(B) of this title—

(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1395p(i)(3) of this title or specified in section 1395p(i)(4)(A)(i) of this title) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(f) Commencement of coverage for certain volunteers serving outside United States

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(k) of this title, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(g) Special enrollment periods for exceptional circumstances

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(m) of this title, the coverage period shall begin on a date the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(h) Coverage period for individuals only eligible for coverage of immunosuppressive drugs

In the case of an individual described in section 1395*o*(b)(1) of this title, the following rules shall apply:

(1) In the case of such an individual who is deemed to have enrolled in part B for coverage of immunosuppressive drugs under section 1395p(n)(3) of this title, such individual's coverage period shall begin on the first day of the month in which the individual first satisfies section 1395*o*(b) of this title.

(2) In the case of such an individual who enrolls (or reenrolls, if applicable) in part B for coverage of immunosuppressive drugs under paragraph (2) or (4) of section 1395p(n) of this title, such individual's coverage period shall begin on January 1, 2023, or the month following the month in which the individual so enrolls (or reenrolls), whichever is later.

(3) The provisions of subsections (b) and (d) shall apply with respect to an individual described in paragraph (1) or (2).

(4) In addition to the reasons for termination under subsection (b), the coverage period of an individual described in paragraph (1) or (2) shall end when the individual becomes entitled to benefits under this subchapter under subsection (a) or (b) of section 426 of this title, or under section 426–1 of this title, or is no longer eligible for such coverage as a result of the application of section 1395*o*(b)(2) of this title.

(5) The Secretary may conduct public education activities to raise awareness of the availability of more comprehensive, individual health insurance coverage (as defined in section 300gg–91 of this title) for individuals eligible under section 1395*o*(b) of this title to enroll or to be deemed enrolled in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

(Aug. 14, 1935, ch. 531, title XVIII, § 1838, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 305; amended Pub. L. 90–248, title I, § 145(c), Jan. 2, 1968, 81 Stat. 859; Pub. L. 92–603, title II, §§ 201(c)(3), 206(b), (c), 257(a), Oct. 30, 1972, 86 Stat. 1373, 1378, 1447; Pub. L. 96–499, title IX, §§ 945(c)(1), 947(b), Dec. 5, 1980, 94 Stat. 2642, 2643; Pub. L. 97–35, title XXI, §§ 2106(b)(2), 2151(a)(3), Aug. 13, 1981, 95 Stat. 792, 802; Pub. L. 98–369, div. B, title III, § 2338(c), July 18, 1984, 98 Stat. 1092; Pub. L. 99–272, title IX, § 9201(c)(2), Apr. 7, 1986, 100 Stat. 171; Pub. L. 99–509, title IX, § 9344(b)(1), Oct. 21, 1986, 100 Stat. 2042; Pub. L. 103–432, title I, § 147(f)(1)(B), Oct. 31, 1994, 108 Stat. 4430; Pub. L. 105–33, title IV, § 4581(b)(2), Aug. 5, 1997, 111 Stat. 465; Pub. L. 108–173, title VII, § 736(b)(6), Dec. 8, 2003, 117 Stat. 2356; Pub. L. 109–171, title V, § 5115(a)(2)(B), Feb. 8, 2006, 120 Stat. 46; Pub. L. 116–260, div. CC, title I, § 120(a)(1), (2)(B), title IV, § 402(a)(2)(B)(i), (c), Dec. 27, 2020, 134 Stat. 2953, 2954, 2999, 3000.)

Editorial Notes

AMENDMENTS

2020—Subsec. (a)(2). Pub. L. 116–260, § 120(a)(1)(A), amended par. (2) generally. Prior to amendment, par. (2) related to coverage period for individuals enrolling pursuant to section 1395p(d) of this title.

Subsec. (a)(3). Pub. L. 116–260, § 120(a)(1)(B), amended par. (3) generally. Prior to amendment, par. (3) read as follows:

''(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1395*o* of this title or July 1, 1973, whichever is later, or

''(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.''

Subsec. (b). Pub. L. 116–260, § 402(c)(2), inserted in concluding provisions ''or section 1395p(n)(3) of this title'' after ''section 1395p(f) of this title'' in two places.

Subsec. (c). Pub. L. 116–260, § 402(a)(2)(B)(i), substituted ''section 1395*o*(a) of this title'' for ''section 1395*o* of this title''.

Subsec. (g). Pub. L. 116–260, § 120(a)(2)(B), added subsec. (g).

Subsec. (h). Pub. L. 116–260, § 402(c)(1), added subsec. (h).

2006—Subsec. (f). Pub. L. 109–171 added subsec. (f).

2003—Subsec. (a)(1). Pub. L. 108–173 inserted comma after ''1966''.

1997—Subsec. (e). Pub. L. 105–33 inserted ''or 1395p(i)(4)(B)'' after ''1395p(i)(3)'' in introductory provisions and ''or specified in section 1395p(i)(4)(A)(i) of this title'' after ''1395p(i)(3) of this title'' in par. (1).

1994—Subsec. (e). Pub. L. 103–432 amended pars. (1) and (2) generally. Prior to amendment, pars. (1) and (2) read as follows:

''(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

''(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.''

1986—Subsec. (b). Pub. L. 99–509 substituted ''month following the month'' for ''calendar quarter following the calendar quarter'' in second and sixth sentences.

Subsec. (e). Pub. L. 99–272 amended subsec. (e) generally. Prior to amendment, subsec. (e) read as follows: ''Notwithstanding subsection (a) of this section, in the case of an individual who enrolls during a special enrollment period pursuant to—

''(1) subparagraph (A) of section 1395p(i)(3) of this title—

''(A) before the month in which he attains the age of 70, the coverage period shall begin on the first day of the month in which he has attained the age of 70, or

''(B) in or after the month in which he attains the age of 70, the coverage period shall begin on the first day of the month following the month in which he so enrolls; or

''(2) subparagraph (B) of section 1395p(i)(3) of this title—

''(A) in the first month of the special enrollment period, the coverage period shall begin on the first day of such month, or

''(B) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which he so enrolls.''

1984—Subsec. (e). Pub. L. 98–369, § 2338(c), added subsec. (e).

1981—Subsec. (a)(2)(E). Pub. L. 97–35, § 2151(a)(3), substituted ''the July 1 following'' for ''the first day of the third month following''.

Subsec. (b). Pub. L. 97–35, § 2106(b)(2), struck out provision that notice filed by an individual enrolled pursuant to section 1395p(f) of this title shall not be considered a disenrollment for purposes of section 1395p(b) of this title.

1980—Subsec. (a)(2)(E). Pub. L. 96–499, § 945(c)(1), substituted ''the first day of the third month'' for ''the July 1''.

Subsec. (b). Pub. L. 96–499, § 947(b), inserted ''(except as otherwise provided in section 1395v(e) of this title)''.

1972—Subsec. (a)(1). Pub. L. 92–603, § 201(c)(3)(A), inserted ''or (in the case of a disabled individual who has not attained age 65) July 1, 1973'' after ''July 1, 1966''.

Subsec. (a)(2). Pub. L. 92–603, § 201(c)(3)(B), substituted in subpar. (A) ''paragraph (1) or (2)'' for ''paragraphs (1) and (2)'' and in subpars. (B) to (D) ''paragraph'' for ''paragraphs''.

Subsec. (a)(3). Pub. L. 92–603, § 206(b), added par. (3).

Subsec. (b). Pub. L. 92–603, §§ 206(c), 257(a), inserted provisions relating to an individual who is deemed to have enrolled for medical insurance pursuant to section 1395p(f) of this title and an individual who is deemed enrolled for medical insurance benefits pursuant to section 1395p(f) of this title and struck out provisions limiting the allowable grace period to 90 days and inserted provision for extension of such period of up to 180 days where failure to pay premiums is due to good cause.

Subsecs. (c), (d). Pub. L. 92–603, § 202(c)(3)(C), added subsec. (c) and redesignated former subsec. (c) as (d).

1968—Subsec. (b). Pub. L. 90–248 struck out '', during a general enrollment period described in section 1395p(e) of this title,'' after ''notice'' in par. (1), and substituted in first sentence following par. (2) ''the calendar quarter following the calendar quarter'' for ''December 31 of the year''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective Jan. 1, 2007, see section 5115(b) of Pub. L. 109–171, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to involuntary terminations of coverage under a group health plan occurring on or after Aug. 5, 1997, see section 4581(c) of Pub. L. 105–33, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective on first day of first month beginning after expiration of the 120-day period that begins on Oct. 31, 1994, see section 147(f)(1)(C) of Pub. L. 103–432, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9344(b)(2), Oct. 21, 1986, 100 Stat. 2042, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to notices filed on or after July 1, 1987.''

Amendment by Pub. L. 99–272 effective May 1, 1986, see section 9201(d)(2) of Pub. L. 99–272, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

For effective date of amendment by Pub. L. 98–369, see section 2338(d)(2) of Pub. L. 98–369, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2106(b)(2) of Pub. L. 97–35 effective Apr. 1, 1981, see section 2106(c) of Pub. L. 97–35, set out as a note under section 1395*l* of this title.

Amendment by section 2151(a)(3) of Pub. L. 97–35 not applicable to enrollments pursuant to written requests for enrollment filed before Oct. 1, 1981, see section 2151(b) of Pub. L. 97–35, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 945(c)(1) of Pub. L. 96–499 applicable to enrollments occurring on or after Apr. 1, 1981, see section 945(d) of Pub. L. 96–499, set out as a note under section 1395p of this title.

Amendment by section 947(b) of Pub. L. 96–499 applicable to notices filed after third calendar month beginning after Dec. 5, 1980, see section 947(d) of Pub. L. 96–499, set out as a note under section 1395v of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 257(b), Oct. 30, 1972, 86 Stat. 1447, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enactment of this Act [Oct. 30, 1972] or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments any premium which became due and payable within such 90-day period shall be considered a premium becoming due and payable on the date of the enactment of this Act.''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Apr. 1, 1968, see section 145(e) of Pub. L. 90–248, set out as a note under section 1395p of this title.

COVERAGE PERIOD; TERMINATION DATES

Pub. L. 90–97, § 3(a), Sept. 30, 1967, 81 Stat. 249, provided that: ''In the case of any individual who, pursuant to section 1838(b)(1) of the Social Security Act [42 U.S.C. 1395q(b)(1)], terminates his enrollment in the insurance program established under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.], his coverage period (as defined in section 1838(a) of such Act) [42 U.S.C. 1395q(a)]—

''(1) shall terminate at the close of December 31, 1967, if he filed his notice of termination before January 1, 1968, or

''(2) shall terminate at the close of March 31, 1968, if he filed his notice of termination after December 31, 1967, and before April 1, 1968.

An individual whose coverage period terminated pursuant to paragraph (1) at the close of December 31, 1967, may, notwithstanding section 1837(b)(2) of such Act [42 U.S.C. 1395p(b)(2)], enroll in such program before April 1, 1968, and for purposes of sections 1838(a)(2)(E) [42 U.S.C. 1395q(a)(2)(E)] and 1837(b)(2) of such Act [42 U.S.C. 1395p(b)(2)] such enrollment shall be deemed an enrollment under section 1837(e) of such Act [42 U.S.C. 1395p(e)] and a second enrollment under such part.''

EXTENSION OF 1967 GENERAL ENROLLMENT PERIOD THROUGH MARCH 31, 1968

Extension of the general enrollment period under section 1395p(e) of this title through March 31, 1968, see section 1 of Pub. L. 90–97, Sept. 30, 1967, 81 Stat. 249, set out as a note under section 1395p of this title.

COVERAGE PERIOD FOR INDIVIDUALS BECOMING ELIGIBLE IN MARCH 1966 WHO ENROLL IN MAY 1966

Pub. L. 89–384, § 3(d), Apr. 8, 1966, 80 Stat. 105, provided that: ''In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 of the Social Security Act [42 U.S.C. 1395*o*] in March, 1966, and who enrolls pursuant to subsection (d) of section 1837 of such Act [42 U.S.C. 1395p] in May 1966, his coverage period shall, notwithstanding section 1838(a)(2)(D) of such Act [42 U.S.C. 1395q(a)(2)(D)], begin on July 1, 1966.''

COMMENCEMENT OF COVERAGE PERIOD OF CERTAIN ENROLLEES

Commencement of coverage period upon enrollment before Oct. 1, 1966 of eligible individuals failing for good cause to enroll before June 1, 1966, see section 102(b) of Pub. L. 89–97, set out as a note under section 1395p of this title.

§ 1395r. Amount of premiums for individuals enrolled under this part

(a) Determination of monthly actuarial rates and premiums

(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Subject to paragraphs (5), (6), and (7), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin. In applying this paragraph there shall not be taken into account additional payments under section 1395w–4(*o*) of this title and section 1395w–23(*l*)(3) of this title and the Government contribution under section 1395w(a)(3) of this title.

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), (f), and (i), and to reflect any credit provided under section 1395w–24(b)(1)(C)(ii)(III) of this title.

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that (except as provided in subsection (g)) is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium rate for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1).

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(5)(A) In applying this part (including subsection (i) and section 1395*l*(b) of this title), the monthly actuarial rate for enrollees age 65 and over for 2016 shall be determined as if subsection (f) did not apply.

(B) Subsection (f) shall continue to be applied to paragraph (6)(A) (during a repayment month, as described in paragraph (6)(B)) and without regard to the application of subparagraph (A).

(6)(A) With respect to a repayment month (as described in subparagraph (B)), the monthly premium otherwise established under paragraph (3) shall be increased by, subject to subparagraph (D), $3.

(B) For purposes of this paragraph, a repayment month is a month during a year, beginning with 2016, for which a balance due amount is computed under subparagraph (C) as greater than zero.

(C) For purposes of this paragraph, the balance due amount computed under this subparagraph, with respect to a month, is the amount estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services to be equal to—

(i) the amount transferred under subsections (d)(1) and (e)(1) of section 1395w of this title; plus

(ii) the amount that is equal to the aggregate reduction, for all individuals enrolled under this part, in the income related monthly adjustment amount as a result of the application of paragraphs (5) and (7); minus

(iii) the amounts payable under this part as a result of the application of this paragraph for preceding months.

(D) If the balance due amount computed under subparagraph (C), without regard to this subparagraph, for December of a year would be less than zero, the Chief Actuary of the Centers for Medicare & Medicaid Services shall estimate, and the Secretary shall apply, a reduction to the dollar amount increase applied under subparagraph (A) for each month during such year in a manner such that the balance due amount for January of the subsequent year is equal to zero.

(7)(A) In applying this part (including subsection (i) and section 1395*l*(b) of this title), the monthly actuarial rate for enrollees age 65 and over for 2021 shall be determined to be equal to the sum of—

(i) the monthly actuarial rate for enrollees age 65 and over for 2020; plus

(ii) 25 percent of the difference between such rate for 2020 and the preliminary monthly actuarial rate for enrollees age 65 and over for 2021 (as estimated under subparagraph (B)).

(B) For purposes of subparagraph (A)(ii), the Secretary shall estimate a preliminary monthly actuarial rate for enrollees age 65 and over for 2021 using the methodology described in paragraph (1) and as if subparagraph (A) of this paragraph did not apply. The Secretary shall make the estimate under the previous sentence as if the transfers described in section 1395w(f)(1) of this title have been made.

(b) Increase in monthly premium

In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1395p of this title) and not pursuant to a special enrollment period under subsection (i)(4), (*l*), or (m) of section 1395p of this title, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or the individual's spouse's) current employment status or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual) or months for which the individual can demonstrate that the individual was an individual described in section 1395p(k)(3) of this title. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence. For purposes of determining any increase under this subsection for individuals whose enrollment occurs on or after January 1, 2023, the second sentence of this subsection shall be applied by substituting ''close of the month'' for ''close of the enrollment period'' each place it appears. No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1395*o*(b) of this title for coverage only of immunosuppressive drugs.

(c) Premiums rounded to nearest multiple of ten cents

If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) "Continuous period of eligibility" defined

For purposes of subsection (b) (and section 1395p(g)(1) of this title), an individual's ''continuous period of eligibility'' is the period beginning with the first day on which he is eligible to enroll under section 1395*o*(a) of this title and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1395*o*(a) of this title and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate ''continuous period of eligibility'' with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

(e) State payment of part B late enrollment premium increases

(1) Upon the request of a State (or any appropriate State or local governmental entity specified by the Secretary), the Secretary may enter into an agreement with the State (or such entity) under which the State (or such entity) agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to

the premiums for eligible individuals (as defined in paragraph (3)(A)).

(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

(3) In this subsection:

(A) The term ''eligible individual'' means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

(B) The term ''part B late enrollment premium increase'' means any increase in a premium as a result of the application of subsection (b).

(f) Limitation on increase in monthly premium

For any calendar year after 1988, if an individual is entitled to monthly benefits under section 402 or 423 of this title or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 [45 U.S.C. 231b(a), 231c(a), (f)] for November and December of the preceding year, if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1395s(a)(1) of this title or section 1395s(b)(1) of this title, and if the amount of the individual's premium is not adjusted for such January under subsection (i), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 402 or 423 of this title or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]. Any increase in the premium for an individual who was enrolled under section 1395*o*(b) of this title attributable to such individual otherwise enrolling under this part shall not be taken into account in applying this subsection.

(g) Exclusions from estimate of benefits and administrative costs

In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to—

(1) the application of section 1395x(v)(1)(L)(viii) of this title or to the establishment under section 1395x(v)(1)(L)(i)(V) of this title of a per visit limit at 106 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this subchapter is not being made under section 1395fff of this title (relating to prospective payment for home health services); and

(2) the medicare prescription drug discount card and transitional assistance program under section 1395w–141 of this title.

(h) Potential application of comparative cost adjustment in CCA areas

(1) In general

Certain individuals who are residing in a CCA area under section 1395w–29[1] of this title who are not enrolled in an MA plan under part C may be subject to a premium adjustment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

(2) No effect on late enrollment penalty or income-related adjustment in subsidies

Nothing in this subsection or section 1395w–29(f)[1] of this title shall be construed as affecting the amount of any premium adjustment under subsection (b) or (i). Subsection (f) shall be applied without regard to any premium adjustment referred to in paragraph (1).

(3) Implementation

In order to carry out a premium adjustment under this subsection and section 1395w–29(f)[1] of this title (insofar as it is effected through the manner of collection of premiums under section 1395s(a) of this title), the Secretary shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the name, social security account number, and the amount of the premium adjustment (if any) for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(i) Reduction in premium subsidy based on income

(1) In general

In the case of an individual whose modified adjusted gross income exceeds the threshold amount under paragraph (2), the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in paragraph (3).

(2) Threshold amount

For purposes of this subsection, subject to paragraph (6), the threshold amount is—

(A) except as provided in subparagraph (B), $80,000 (or, beginning with 2018, $85,000), and

(B) in the case of a joint return, twice the amount applicable under subparagraph (A) for the calendar year.

(3) Monthly adjustment amount

(A) In general

Subject to subparagraph (B), the monthly adjustment amount specified in this paragraph for an individual for a month in a year is equal to the product of the following:

[1] See References in Text note below.

(i) Sliding scale percentage

Subject to paragraph (6), the applicable percentage specified in the applicable table in subparagraph (C) for the individual minus 25 percentage points.

(ii) Unsubsidized part B premium amount

(I) 200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year); plus

(II) 4 times the amount of the increase in the monthly premium under subsection (a)(6) for a month in the year (or, with respect to an individual enrolled under section 1395*o*(b) of this title and not otherwise enrolled under this part, 0 times the amount of such increase).

(B) 3-year phase in

The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2009 is equal to the following percentage of the monthly adjustment amount specified in subparagraph (A):

(i) For 2007, 33 percent.

(ii) For 2008, 67 percent.

(C) Applicable percentage

(i) In general

(I) Subject to paragraphs (5) and (6), for years before 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than $80,000 but not more than $100,000	35 percent
More than $100,000 but not more than $150,000	50 percent
More than $150,000 but not more than $200,000	65 percent
More than $200,000	80 percent.

(II) Subject to paragraph (5), for 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than $85,000 but not more than $107,000	35 percent
More than $107,000 but not more than $133,500	50 percent
More than $133,500 but not more than $160,000	65 percent
More than $160,000	80 percent.

(III) Subject to paragraph (5), for years beginning with 2019:

If the modified adjusted gross income is:	The applicable percentage is:
More than $85,000 but not more than $107,000	35 percent
More than $107,000 but not more than $133,500	50 percent
More than $133,500 but not more than $160,000	65 percent
More than $160,000 but less than $500,000	80 percent
At least $500,000	85 percent.

(ii) Joint returns

In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year except, with respect to the dollar amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year.

(iii) Married individuals filing separate returns

In the case of an individual who—

(I) is married as of the close of the taxable year (within the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

(II) does not live apart from such individual's spouse at all times during the taxable year,

clause (i) shall be applied by reducing each of the dollar amounts otherwise applicable under such clause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

(4) Modified adjusted gross income

(A) In general

For purposes of this subsection, the term ''modified adjusted gross income'' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code.

In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

(B) Taxable year to be used in determining modified adjusted gross income

(i) In general

In applying this subsection for an individual's premiums in a month in a year, subject to clause (ii) and subparagraph (C), the individual's modified adjusted gross income shall be such income determined for the individual's last taxable year beginning in the second calendar year preceding the year involved.

(ii) Temporary use of other data

If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when

adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

(iii) Non-filers

In the case of individuals with respect to whom the Secretary of the Treasury does not have adequate data in appropriate electronic form for either taxable year referred to in clause (i) or clause (ii), the Commissioner of Social Security, in consultation with the Secretary, shall prescribe regulations which provide for the treatment of the premium adjustment with respect to such individual under this subsection, including regulations which provide for—

(I) the application of the highest applicable percentage under paragraph (3)(C) to such individual if the Commissioner has information which indicates that such individual's modified adjusted gross income might exceed the threshold amount for the taxable year referred to in clause (i), and

(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent with such individual's modified adjusted gross income for such taxable year.

(C) Use of more recent taxable year

(i) In general

The Commissioner of Social Security in consultation with the Secretary of the Treasury shall establish a procedures under which an individual's modified adjusted gross income shall, at the request of such individual, be determined under this subsection—

(I) for a more recent taxable year than the taxable year otherwise used under subparagraph (B), or

(II) by such methodology as the Commissioner, in consultation with such Secretary, determines to be appropriate, which may include a methodology for aggregating or disaggregating information from tax returns in the case of marriage or divorce.

(ii) Standard for granting requests

A request under clause (i)(I) to use a more recent taxable year may be granted only if—

(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

(5) Inflation adjustment

(A) In general

Subject to subparagraph (C), in the case of any calendar year beginning after 2007 (other than 2018 and 2019), each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2006 (or, in the case of a calendar year beginning with 2020, August 2018).

(B) Rounding

If any dollar amount after being increased under subparagraph (A) or (C) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

(C) Treatment of adjustments for certain higher income individuals

(i) In general

Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of $500,000.

(ii) Adjustment beginning 2028

In the case of any calendar year beginning after 2027, each dollar amount in paragraph (3) of $500,000 shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2026.

(6) Temporary adjustment to income thresholds

Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2017—

(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

(7) Joint return defined

For purposes of this subsection, the term ''joint return'' has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

(j) Determination of premium for individuals only eligible for coverage of immunosuppressive drugs

The Secretary shall, during September of each year (beginning with 2022), determine and promulgate a monthly premium rate for the succeeding calendar year for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1395*o*(b) of this title. Such premium shall be equal to 15 percent of the monthly actuarial rate for enrollees age 65 and over (as would be determined in accordance with subsection (a)(1) if the reference to ''one-half'' in such subsection were a reference to ''100 percent'') for that succeeding calendar year. The monthly premium of each individual enrolled for coverage of immunosuppressive drugs under section 1395*o*(b) of this title for each month shall be the amount promulgated in this subsection. In the case of such individual not otherwise enrolled under this part, such premium shall be in lieu of any other monthly premium applicable under this section. Such amount shall be adjusted in accordance with subsections (c), (f), and (i), but shall not be adjusted under subsection (b).

(Aug. 14, 1935, ch. 531, title XVIII, § 1839, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 305; amended Pub. L. 90–248, title I, § 145(d), Jan. 2, 1968, 81 Stat. 859; Pub. L. 92–603, title II, §§ 201(c)(4), (5), 203 (a)–(d), Oct. 30, 1972, 86 Stat. 1373, 1376, 1377; Pub. L. 94–182, title I, § 104(a), Dec. 31, 1975, 89 Stat. 1052; Pub. L. 95–216, title II, § 205(e), Dec. 20, 1977, 91 Stat. 1529; Pub. L. 96–499, title IX, § 945(c)(2), Dec. 5, 1980, 94 Stat. 2642; Pub. L. 97–35, title XXI, § 2151(a)(4), Aug. 13, 1981, 95 Stat. 802; Pub. L. 97–248, title I, § 124(a), (b), Sept. 3, 1982, 96 Stat. 364; Pub. L. 97–448, title III, § 309(b)(8), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, § 606(a)(1)–(3)(C), Apr. 20, 1983, 97 Stat. 169, 170; Pub. L. 98–369, div. B, title III, §§ 2302(a), (b), 2338(a), July 18, 1984, 98 Stat. 1063, 1091; Pub. L. 98–617, § 3(b)(4), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§ 9219(a)(1), 9313, Apr. 7, 1986, 100 Stat. 182, 194; Pub. L. 99–509, title IX, §§ 9001(c), 9319(c)(4), Oct. 21, 1986, 100 Stat. 1970, 2012; Pub. L. 100–203, title IV, § 4080, Dec. 22, 1987, 101 Stat. 1330–126; Pub. L. 100–360, title II, § 211(a)–(c)(1), July 1, 1988, 102 Stat. 733, 738; Pub. L. 100–485, title VI, § 608(d)(9), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, § 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6202(b)(4)(C), (c)(2), 6301, Dec. 19, 1989, 103 Stat. 2233, 2234, 2258; Pub. L. 101–508, title IV, § 4301, Nov. 5, 1990, 104 Stat. 1388–125; Pub. L. 103–66, title XIII, § 13571, Aug. 10, 1993, 107 Stat. 609; Pub. L. 103–432, title I, §§ 144, 151(c)(3), Oct. 31, 1994, 108 Stat. 4427, 4435; Pub. L. 105–33, title IV, §§ 4571(a), (b)(1), 4581(a), 4582, 4631(a)(2), Aug. 5, 1997, 111 Stat. 464, 465, 486; Pub. L. 105–277, div. J, title V, § 5101(e), Oct. 21, 1998, 112 Stat. 2681–915; Pub. L. 106–554, § 1(a)(6) [title VI, § 606(a)(2)(B)(i)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557; Pub. L. 108–173, title I, § 105(a), title II, §§ 222(*l*)(2)(A), 241(b)(2)(A), title VI, § 625(a)(1), title VII, § 736(b)(7), title VIII, § 811(a), (b)(1), Dec. 8, 2003, 117 Stat. 2166, 2206, 2220, 2317, 2356, 2364, 2367; Pub. L. 109–171, title V, §§ 5111, 5115(a)(1), Feb. 8, 2006, 120 Stat. 43, 45; Pub. L. 111–5, div. B, title IV, § 4103(a)(1), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111–148, title III, §§ 3110(b), 3402, Mar. 23, 2010, 124 Stat. 420, 488; Pub. L. 114–10, title IV, § 402, Apr. 16, 2015, 129 Stat. 160; Pub. L. 114–74, title VI, § 601(a), (c), Nov. 2, 2015, 129 Stat. 594, 595; Pub. L. 115–123, div. E, title XII, § 53114, Feb. 9, 2018, 132 Stat. 305; Pub. L. 116–159, div. C, title IV, § 2401(a), (d), Oct. 1, 2020, 134 Stat. 732, 733; Pub. L. 116–260, div. CC, title I, § 120(a)(2)(C)(ii), (3), title IV, § 402(a)(2)(B)(i), (d), Dec. 27, 2020, 134 Stat. 2954, 2999, 3000.)

Editorial Notes

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (f), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, § 101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§ 231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395w–29 of this title, referred to in subsec. (h), was repealed by Pub. L. 111–152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (i)(3)(C)(iii)(I), (4)(A), (7), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2020—Subsec. (a)(1). Pub. L. 116–159, § 2401(a)(1), substituted ''(5), (6), and (7)'' for ''(5) and (6)''.

Subsec. (a)(6)(C)(i). Pub. L. 116–159, § 2401(a)(2)(A), substituted ''subsections (d)(1) and (e)(1) of section 1395w of this title'' for ''section 1395w(d)(1) of this title''.

Subsec. (a)(6)(C)(ii). Pub. L. 116–159, § 2401(a)(2)(B), substituted ''paragraphs (5) and (7)'' for ''paragraph (5)''.

Subsec. (a)(7). Pub. L. 116–159, § 2401(a)(3), added par. (7).

Subsec. (b). Pub. L. 116–260, § 402(d)(1)(A), inserted at end ''No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1395*o*(b) of this title for coverage only of immunosuppressive drugs.''

Pub. L. 116–260, § 120(a)(2)(C)(ii), (3), substituted ''(i)(4), (*l*), or (m)'' for ''(i)(4) or (*l*)'' and inserted at end ''For purposes of determining any increase under this subsection for individuals whose enrollment occurs on or after January 1, 2023, the second sentence of this subsection shall be applied by substituting 'close of the month' for 'close of the enrollment period' each place it appears.''

Subsec. (d). Pub. L. 116–260, § 402(a)(2)(B)(i), substituted ''section 1395*o*(a) of this title'' for ''section 1395*o* of this title'' in two places.

Subsec. (f). Pub. L. 116–260, § 402(d)(2), inserted at end ''Any increase in the premium for an individual who was enrolled under section 1395*o*(b) of this title attributable to such individual otherwise enrolling under this part shall not be taken into account in applying this subsection.''

Subsec. (i)(3)(A)(ii)(I). Pub. L. 116–159, § 2401(d), realigned margins.

Subsec. (i)(3)(A)(ii)(II). Pub. L. 116–260, § 402(d)(3), inserted ''(or, with respect to an individual enrolled under section 1395*o*(b) of this title and not otherwise enrolled under this part, 0 times the amount of such increase)'' after ''in the year''.

Subsec. (j). Pub. L. 116–260, § 402(d)(1)(B), added subsec. (j).

2018—Subsec. (i)(3)(C)(i)(II). Pub. L. 115–123, § 53114(a)(1), struck out ''years beginning with'' after ''Subject to paragraph (5), for''.

Subsec. (i)(3)(C)(i)(III). Pub. L. 115–123, § 53114(a)(2), added subcl. (III).

Subsec. (i)(3)(C)(ii). Pub. L. 115–123, § 53114(b), inserted before period at end ''except, with respect to the dollar

amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year''.

Subsec. (i)(5)(A). Pub. L. 115–123, § 53114(c)(1), substituted ''Subject to subparagraph (C), in the case'' for ''In the case'' in introductory provisions.

Subsec. (i)(5)(B). Pub. L. 115–123, § 53114(c)(2), substituted ''subparagraph (A) or (C)'' for ''subparagraph (A)''.

Subsec. (i)(5)(C). Pub. L. 115–123, § 53114(c)(3), added subpar. (C).

2015—Subsec. (a)(1). Pub. L. 114–74, § 601(a)(1), substituted ''Subject to paragraphs (5) and (6), such actuarial'' for ''Such actuarial'' in second sentence.

Subsec. (a)(5), (6). Pub. L. 114–74, § 601(a)(2), added pars. (5) and (6).

Subsec. (i)(2)(A). Pub. L. 114–10, § 402(b)(1), inserted ''(or, beginning with 2018, $85,000)'' after ''$80,000''.

Subsec. (i)(3)(A)(i). Pub. L. 114–10, § 402(b)(2), inserted ''applicable'' before ''table''.

Subsec. (i)(3)(A)(ii). Pub. L. 114–74, § 601(c), designated existing provisions as subcl. (I), substituted ''year); plus'' for ''year).'', and added subcl. (II).

Subsec. (i)(3)(C)(i). Pub. L. 114–10, § 402(a), designated existing provisions as subcl. (I) and inserted introductory provisions and added subcl. (II).

Subsec. (i)(5)(A). Pub. L. 114–10, § 402(b)(3)(A), inserted ''(other than 2018 and 2019)'' after ''2007'' in introductory provisions.

Subsec. (i)(5)(A)(ii). Pub. L. 114–10, § 402(b)(3)(B), inserted ''(or, in the case of a calendar year beginning with 2020, August 2018)'' after ''August 2006''.

Subsec. (i)(6). Pub. L. 114–10, § 402(b)(4), substituted ''2017'' for ''2019'' in introductory provisions.

2010—Subsec. (b). Pub. L. 111–148, § 3110(b), substituted ''subsection (i)(4) or (*l*) of section 1395p'' for ''section 1395p(i)(4)''.

Subsec. (i)(2). Pub. L. 111–148, § 3402(1), inserted ''subject to paragraph (6),'' after ''subsection,'' in introductory provisions.

Subsec. (i)(3)(A)(i). Pub. L. 111–148, § 3402(2), substituted ''Subject to paragraph (6), the applicable'' for ''The applicable''.

Subsec. (i)(6), (7). Pub. L. 111–148, § 3402(3), (4), added par. (6) and redesignated former par. (6) as (7).

2009—Subsec. (a)(1). Pub. L. 111–5 inserted at end ''In applying this paragraph there shall not be taken into account additional payments under section 1395w–4(*o*) of this title and section 1395w–23(*l*)(3) of this title and the Government contribution under section 1395w(a)(3) of this title.''

2006—Subsec. (b). Pub. L. 109–171, § 5115(a)(1), inserted ''or months for which the individual can demonstrate that the individual was an individual described in section 1395p(k)(3) of this title'' before period at end of second sentence.

Subsec. (i)(3)(B). Pub. L. 109–171, § 5111(1), (2), substituted ''3-year'' for ''5-year'' in heading and ''2009'' for ''2011'' in introductory provisions.

Subsec. (i)(3)(B)(i). Pub. L. 109–171, § 5111(3), substituted ''33 percent'' for ''20 percent''.

Subsec. (i)(3)(B)(ii). Pub. L. 109–171, § 5111(4), substituted ''67 percent'' for ''40 percent''.

Subsec. (i)(3)(B)(iii), (iv). Pub. L. 109–171, § 5111(5), struck out cls. (iii) and (iv), which read as follows:

''(iii) For 2009, 60 percent.

''(iv) for 2010, 80 percent.''

2003—Subsec. (a)(2). Pub. L. 108–173, § 811(b)(1)(A), substituted ''(f), and (i)'' for ''and (f)''.

Pub. L. 108–173, § 222(*l*)(2)(A), substituted ''any credit provided under section 1395w–24(b)(1)(C)(ii)(III)'' for ''80 percent of any reduction elected under section 1395w–24(f)(1)(E)''.

Subsec. (a)(4). Pub. L. 108–173, § 736(b)(7), substituted ''will equal one-half of the total'' for ''which will equal one-half of the total''.

Subsec. (b). Pub. L. 108–173, § 811(b)(1)(B), inserted ''(without regard to any adjustment under subsection (i))'' after ''subsection (a)''.

Pub. L. 108–173, § 625(a)(1), inserted at end ''No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''

Subsec. (f). Pub. L. 108–173, § 811(b)(1)(C), substituted ''if the monthly premium'' for ''and if the monthly premium'' and inserted ''and if the amount of the individual's premium is not adjusted for such January under subsection (i),'' after ''section 1395s(b)(1) of this title,''.

Subsec. (g). Pub. L. 108–173, § 105(a), substituted ''attributable to—'' for ''attributable to'', inserted par. (1) designation before ''the application of'', substituted ''; and'' for period at end, and added par. (2).

Subsec. (h). Pub. L. 108–173, § 241(b)(2)(A), added subsec. (h).

Subsec. (i). Pub. L. 108–173, § 811(a), added subsec. (i).

2000—Subsec. (a)(2). Pub. L. 106–554 substituted ''shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f), and to reflect 80 percent of any reduction elected under section 1395w–24(f)(1)(E) of this title.'' for ''shall, except as provided in subsections (b), (c), and (f), be the amount determined under paragraph (3).''

1998—Subsec. (a)(3). Pub. L. 105–277, § 5101(e)(1), inserted ''(except as provided in subsection (g))'' after ''year that''.

Subsec. (g). Pub. L. 105–277, § 5101(e)(2), added subsec. (g).

1997—Subsec. (a)(2). Pub. L. 105–33, § 4571(b)(1)(A), substituted ''subsections (b), (c), and (f)'' for ''subsections (b) and (e)''.

Subsec. (a)(3). Pub. L. 105–33, § 4571(b)(1)(B), in last sentence, inserted ''rate'' after ''monthly premium'' and struck out ''and the derivation of the dollar amounts specified in this paragraph'' before period at end.

Pub. L. 105–33, § 4571(a), substituted ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.'' for ''The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e) of this section) be equal to the smaller of—

''(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

''(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 415(a)(1) of this title, based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.''

Subsec. (b). Pub. L. 105–33, § 4631(a)(2), substituted ''1395y(b)(1)(B)(iii) of this title'' for ''1395y(b)(1)(B)(iv) of this title'' in second sentence.

Pub. L. 105–33, § 4571(b)(1)(C), struck out ''or (e)'' after ''determined under subsection (a)'' in first sentence.

Pub. L. 105–33, § 4581(a), inserted ''and not pursuant to a special enrollment period under section 1395p(i)(4) of

this title'' after ''section 1395p of this title)'' in first sentence.

Subsec. (e). Pub. L. 105–33, §4571(b)(1)(D), (E), redesignated subsec. (g) as (e) and struck out former subsec. (e) which read as follows:

''(1)(A) Notwithstanding the provisions of subsection (a) of this section, the monthly premium for each individual enrolled under this part for each month after after December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) of this section and applicable to such month.

''(B) Notwithstanding the provisions of subsection (a) of this section, the monthly premium for each individual enrolled under this part for each month in—

''(i) 1991 shall be $29.90,

''(ii) 1992 shall be $31.80,

''(iii) 1993 shall be $36.60,

''(iv) 1994 shall be $41.10, and

''(v) 1995 shall be $46.10.

''(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3) of this section.''

Subsec. (e)(1). Pub. L. 105–33, §4582, inserted ''(or any appropriate State or local governmental entity specified by the Secretary)'' after ''request of a State'' and inserted ''(or such entity)'' after ''agreement with the State'' and after ''which the State''.

Subsec. (g). Pub. L. 105–33, §4571(b)(1)(E), redesignated subsec. (g) as (e).

1994—Subsec. (b). Pub. L. 103–432, §151(c)(3), in second sentence, inserted ''status'' after ''current employment'' and substituted ''(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)'' for ''as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)''.

Subsec. (g). Pub. L. 103–432, §144, added subsec. (g).

1993—Subsec. (e)(1)(A). Pub. L. 103–66, §13571(1), substituted ''after December 1995 and prior to January 1999 shall be an amount equal to 50 percent'' for ''December 1983 and prior to January 1991 shall be an amount equal to 50 percent''.

Subsec. (e)(2). Pub. L. 103–66, §13571(2), substituted ''1998'' for ''1991''.

1990—Subsec. (e)(1). Pub. L. 101–508 designated existing provisions as subpar. (A) and added subpar. (B).

1989—Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(A)–(D), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (b). Pub. L. 101–239, §6202(c)(2), struck out ''during which the individual has attained the age of 65 and'' after ''into account months'' in second sentence.

Pub. L. 101–239, §6202(b)(4)(C), substituted ''section 1395y(b)(1)(A)(v)'' and ''section 1395y(b)(1)(B)(iv)'' for ''section 1395y(b)(3)(A)(iv)'' and ''section 1395y(b)(4)(B)'', respectively.

Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(E), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e). Pub. L. 101–239, §6301, substituted ''1991'' for ''1990'' wherever appearing.

Subsec. (e)(1). Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(F), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (g). Pub. L. 101–234 repealed Pub. L. 100–360, §211(a), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(1). Pub. L. 100–360, §211(c)(1)(A), (B), inserted ''(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)'' before period at end of second sentence, and '', but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account'' before period at end of last sentence.

Subsec. (a)(2). Pub. L. 100–360, §211(c)(1)(C), substituted '', (e), and (g)'' for ''and (e)''.

Subsec. (a)(3). Pub. L. 100–360, §211(c)(1)(D), substituted ''subsections (e) and (g)'' for ''subsection (e)'' in introductory provisions.

Subsec. (a)(4). Pub. L. 100–360, §211(c)(1)(A), (B), inserted ''(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)'' before period at end of second sentence, and '', but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account'' before period at end of last sentence.

Subsec. (b). Pub. L. 100–360, §211(c)(1)(E), substituted ''otherwise determined under this section (without regard to subsections (f) and (g)(6))'' for ''determined under subsection (a) or (e)''.

Subsec. (e)(1). Pub. L. 100–360, §211(c)(1)(F), inserted ''except as provided in subsection (g) of this section,'' after ''subsection (a) of this section''.

Subsec. (f). Pub. L. 100–485, §608(d)(8)(B), substituted ''for that December below the amount of benefits payable to that individual for that November'' for ''for that January below the amount of benefits payable to that individual for that December''.

Pub. L. 100–360, §211(b), amended subsec. (f) generally, substituting a single paragraph for former pars. (1) and (2).

Subsec. (g). Pub. L. 100–360, §211(a), added subsec. (g) relating to adjustment in medicare part B premium.

Subsec. (g)(1)(B)(iii)(I). Pub. L. 100–485, §608(d)(9)(A)(i), substituted ''year, over'' for ''year, and''.

Subsec. (g)(1)(B)(iii)(II). Pub. L. 100–485, §608(d)(9)(A)(ii), substituted ''supplemental premium rate'' for ''supplemental rate''.

Subsec. (g)(7)(A)(ii). Pub. L. 100–485, §608(d)(9)(A)(iii), substituted ''of each such year'' for ''of such year''.

1987—Subsec. (e). Pub. L. 100–203, §4080(1), substituted ''1990'' for ''1989'' wherever appearing.

Subsec. (f)(1). Pub. L. 100–203, §4080(2), substituted ''1987, or 1988'' for ''or 1987''.

Subsec. (f)(2). Pub. L. 100–203, §4080(3), substituted ''1988, or 1989'' for ''or 1988''.

1986—Subsec. (b). Pub. L. 99–509, §9319(c)(4), inserted ''or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1395y(b)(4)(B) of this title)'' at end of second sentence.

Pub. L. 99–272, §9219(a)(1), substituted ''months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1395y(b)(3)(A)(iv) of this title'' for ''months in which the individual has met the conditions specified in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section''.

Subsec. (e). Pub. L. 99–272, §9313(1), substituted ''1989'' for ''1988'' wherever appearing.

Subsec. (f)(1). Pub. L. 99–272, §9313(2), substituted '', 1986, or 1987'' for ''or 1986''.

Subsec. (f)(2). Pub. L. 99–272, §9313(3), substituted '', 1987, or 1988'' for ''or 1987''.

Subsec. (f)(2)(A). Pub. L. 99–509, §9001(c), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''the monthly premium amount determined under subsection (a)(2) of this section for that January reduced by the amount (if any) necessary to

make the monthly benefits under section 402 or 423 of this title for that December after the deduction of the monthly premium (disregarding subsection (b) of this section) for that January at least equal to the monthly benefits under section 402 or 423 of this title for the preceding November after the deduction of the premium (disregarding subsection (b) of this section) for that individual for that December, or''.

1984—Subsec. (b). Pub. L. 98–369, § 2338(a), inserted provision that there shall not be taken into account months in which the individual has met conditions specified in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section by reason of the individual's (or the individual's spouse's) current employment.

Subsec. (e). Pub. L. 98–369, § 2302(a), substituted ''1988'' for ''1986'' in pars. (1) and (2).

Subsec. (f). Pub. L. 98–369, § 2302(b), added subsec. (f).

Subsec. (f)(2)(A). Pub. L. 98–617, § 3(b)(4), substituted ''for that December after the deduction'' for ''for that January after the deduction'' and ''for that December'' for ''for that November''.

1983—Subsec. (a). Pub. L. 98–21, § 606(a)(1), added subsec. (a) and struck out former subsec. (a) which provided that monthly premium of each individual enrolled under this part for each month before 1968 would be $3.

Subsec. (b). Pub. L. 98–21, § 606(a)(3)(A), substituted ''subsection (a) or (e)'' for ''subsection (b), (c), or (g)''.

Pub. L. 98–21, § 606(a)(1), (2), redesignated subsec. (d) as (b), and struck out former subsec. (b) which provided for determination by Secretary of monthly premium for each individual enrolled under this part for each month after 1967 and before July 1, 1973.

Subsec. (c). Pub. L. 98–21, § 606(a)(1), (2), redesignated subsec. (e) as (c), and struck out former subsec. (c) which directed Secretary to determine during December of each year after 1972 the monthly actuarial rate for enrollees age 65 and over applicable to succeeding fiscal year (beginning July 1), provided for his determination of monthly premium for such period, and directed him to determine monthly actuarial rate for disabled enrollees under age 65.

Subsec. (d). Pub. L. 98–21, § 606(a)(3)(B), which directed that ''purposes of subsection (b)'' be substituted for ''purposes of subsection (c)'' was executed by substituting ''purposes of subsection (b)'' for ''purposes of subsection (d)'', as the probable intent of Congress in view of previous substitution of ''subsection (d)'' for ''subsection (c)'' by Pub. L. 92–603, § 203(d)(2).

Pub. L. 98–21, § 606(a)(2), redesignated subsec. (f) as (d). Former subsec. (d) redesignated (b).

Pub. L. 97–448 inserted reference to determination of monthly premium pursuant to subsec. (g) of this section.

Subsec. (e). Pub. L. 98–21, § 606(a)(2), redesignated subsec. (g) as (e). Former subsec. (e) redesignated (c).

Subsec. (e)(1). Pub. L. 98–21, § 606(a)(3)(C), substituted ''(a)'' for ''(c)'', ''(a)(1)'' for ''(c)(1)'', ''December 1983'' for ''June 1983'', and ''January 1986'' for ''July 1985''.

Subsec. (e)(2). Pub. L. 98–21, § 606(a)(3)(C)(i), (iii), substituted ''(a)(3)'' for ''(c)(3)'' and ''January 1986'' for ''July 1985''.

Subsecs. (f), (g). Pub. L. 98–21, § 606(a)(2), redesignated subsecs. (f) and (g) as (d) and (e), respectively.

1982—Subsec. (c)(2). Pub. L. 97–248, § 124(a)(1), substituted ''except as provided in subsections (d) and (g)'' for ''except as provided in subsection (d)''.

Subsec. (c)(3). Pub. L. 97–248, § 124(a)(2), inserted ''(except as otherwise provided in subsection (g) of this section)''.

Subsec. (g). Pub. L. 97–248, § 124(b), added subsec. (g).

1981—Subsec. (d). Pub. L. 97–35 substituted ''the close of the enrollment period in which he reenrolled'' for ''the month after the month in which he reenrolled'' in cl. (2).

1980—Subsec. (d). Pub. L. 96–499 substituted ''who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled'' for ''who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time''.

1977—Subsec. (c)(3)(B). Pub. L. 95–216 substituted ''the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 415(a)(1) of this title, based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on May 1 of the year of the promulgation'' for ''the monthly premium rate most recently promulgated by the Secretary under this paragraph or, in the case of the determination made in December 1971, such rate promulgated under subsection (b)(2) of this section multiplied by the ratio of (i) the amount in column IV of the table which, by reason of the law in effect at the time the promulgation is made, will be in effect as of May 1 next following such determination appears (or is deemed to appear) in section 415(a) of this title on the line which includes the figure '750' in column III of such table to (ii) the amount in column IV of the table which appeared (or was deemed to appear) in section 415(a) of this title on the line which included the figure '750' in column III as of May 1 of the year in which such determination is made'' and inserted ''He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals on the following May 1.''

1975—Subsec. (c)(3). Pub. L. 94–182 substituted ''May 1'' for ''June 1'' wherever appearing.

1972—Subsec. (b)(1). Pub. L. 92–603, § 203(a), inserted ''and before July 1, 1973'' following ''1967''.

Subsec. (b)(2). Pub. L. 92–603, § 203(b), substituted ''ending on or before December 31, 1971'' for ''thereafter''.

Subsec. (c). Pub. L. 92–603, § 203(c), added subsec. (c). Former subsec. (c) redesignated (d).

Subsec. (d). Pub. L. 92–603, §§ 201(c)(4), 203(c), (d)(1), redesignated former subsec. (c) as (d), inserted reference to subsec. (c) after reference to subsec. (b), inserted ''(in the same continuous period of eligibility)'' after ''for each full 12 months'', and inserted provisions relating to any increase in an individual's monthly premium under the first sentence of this subsection. Former subsec. (d) redesignated (e).

Subsec. (e). Pub. L. 92–603, § 203(c), redesignated former subsec. (d) as (e). Former subsec. (e) redesignated (f).

Pub. L. 92–603, § 201(c)(5), added subsec. (e).

Subsec. (f). Pub. L. 92–603, § 203(c), (d)(2), redesignated former subsec. (e) as (f) and substituted ''subsection (d)'' for ''subsection (c)''.

1968—Subsec. (b)(2). Pub. L. 90–248 required Secretary, during December of each year, beginning in 1968, to determine and announce amount (whether or not such amount was applicable for premiums for any prior month) of supplementary medical insurance premium for 12-month period beginning on July 1 of each following year, which premium is to be such that aggregate premiums will equal one-half estimated benefit and administrative expenses of supplementary medical insurance program for such 12-month period, and that at time of announcement of premium amount, Secretary must make public actuarial assumptions and bases used in deciding amount of premium.

Statutory Notes and Related Subsidiaries

Effective Date of 2006 Amendment

Amendment by section 5115(a)(1) of Pub. L. 109–171 applicable to months beginning with Jan. 2007, see section 5115(b) of Pub. L. 109–171, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(*l*)(2)(A) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Pub. L. 108–173, title VI, §625(a)(2), Dec. 8, 2003, 117 Stat. 2318, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to premiums for months beginning with January 2004. The Secretary [of Health and Human Services] shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §606(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558, provided that: ''The amendments made by subsection (a) [amending this section and sections 1395s, 1395w, 1395w–21, 1395w–23, and 1395w–24 of this title] shall apply to years beginning with 2003.''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4581(a) of Pub. L. 105–33 applicable to involuntary terminations of coverage under a group health plan occurring on or after Aug. 5, 1997, see section 4581(c) of Pub. L. 105–33, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §151(c)(3), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6202(b)(4)(C) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 6202(c)(2) of Pub. L. 101–239 applicable to enrollments occurring after, and premiums for months after, second calendar quarter beginning after Dec. 19, 1989, see section 6202(c)(3) of Pub. L. 101–239, set out as a note under section 1395p of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title II, §211(d), July 1, 1988, 102 Stat. 739, which provided that the amendments made by section 211 of Pub. L. 100–360 [amending this section and sections 1395w and 1395mm of this title] applied (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989, was repealed by Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9001(c) of Pub. L. 99–509 applicable with respect to monthly premiums under this section for months after December 1986, see section 9001(d)(3) of Pub. L. 99–509, set out as a note under section 415 of this title.

Amendment by section 9319(c)(4) of Pub. L. 99–509 applicable to enrollments occurring on or after Jan. 1, 1987, see section 9319(f)(2) of Pub. L. 99–509 set out as a note under section 1395y of this title.

Pub. L. 99–272, title IX, §9219(a)(3)(A), Apr. 7, 1986, 100 Stat. 182, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to months beginning with January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of the enactment of this Act [Apr. 7, 1986].''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2302(c), July 18, 1994, 98 Stat. 1064, provided that: ''The amendments made by this section [amending this section] shall apply to premiums for months beginning with January 1986.''

Pub. L. 98–369, div. B, title III, §2338(d)(1), July 18, 1994, 98 Stat. 1093, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to months beginning with January 1983 for premiums for months beginning with the first month which begins more than 30 days after the date of the enactment of this Act [July 18, 1984].''

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Pub. L. 98–21, title VI, §606(c), Apr. 20, 1983, 97 Stat. 171, provided that: ''The amendments made by this section [amending this section and sections 1395i–2, 1395v, 1395w, and 1395mm of this title] shall apply to premiums for months beginning with January 1984, and for months after June 1983 and before January 1984—

''(1) the monthly premiums under part A and under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for individuals enrolled under each respective part shall be the monthly premium under that part for the month of June 1983, and

''(2) the amount of the Government contributions under section 1844(a)(1) of such Act [42 U.S.C. 1395w(a)(1)] shall be computed on the basis of the actuarially adequate rate which would have been in effect under part B of title XVIII of such Act for such months without regard to the amendments made by this section, but using the amount of the premium in effect for the month of June 1983.''

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

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 not applicable to enrollments pursuant to written requests for enrollment filed before Oct. 1, 1981, see section 2151(b) of Pub. L. 97–35, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–499 applicable to enrollments occurring on or after Apr. 1, 1981, see section 945(d) of Pub. L. 96–499, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective with respect to monthly benefits and lump-sum death payments for deaths occurring after December 1978, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §104(b), Dec. 31, 1975, 89 Stat. 1052, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to determinations made under section 1839(c)(3) of

the Social Security Act [42 U.S.C. 1395r(c)(3)] after the date of the enactment of this Act [Dec. 31, 1975].''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Dec. 1, 1968, see section 145(e) of Pub. L. 90–248, set out as a note under section 1395p of this title.

CONSTRUCTION REGARDING NO AUTHORITY TO INITIATE APPLICATION TO YEARS AFTER 2017

Pub. L. 114–74, title VI, § 601(e), Nov. 2, 2015, 129 Stat. 596, provided that: ''Nothing in subsection (d) [set out as a note below] or the amendments made by this section [amending this section and secton 1395w of this title] shall be construed as authorizing the Secretary of Health and Human Services to initiate application of such subsection or amendments for a year after 2017.''

CONDITIONAL APPLICATION TO 2017 IF NO SOCIAL SECURITY COLA FOR 2017

Pub. L. 114–74, title VI, § 601(d), Nov. 2, 2015, 129 Stat. 596, provided that: ''If there is no increase in the monthly insurance benefits payable under title II [probably means title II of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 401 et seq.] with respect to December 2016 pursuant to section 215(i) [probably means section 215(i) of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 415(i)], then the amendments made by this section [amending this section and secton 1395w of this section] shall be applied as if—

''(1) the reference to '2016' in paragraph (5)(A) of section 1839(a) of the Social Security Act (42 U.S.C. 1395r(a)), as added by subsection (a)(2), was a reference to '2016 and 2017';

''(2) the reference to 'a month during a year, beginning with 2016' in paragraph (6)(B) of section 1839 of such Act (42 U.S.C. 1395r(a)), as added by subsection (a)(2), was a reference to 'a month in a year, beginning with 2016 and beginning with 2017, respectively'; and

''(3) the reference to '2016' in subsection (d)(1) of section 1844 of such Act (42 U.S.C. 1395w), as added by subsection (b)(2), was a reference to 'each of 2016 and 2017'

Any increase in premiums effected under this subsection shall be in addition to the increase effected by the amendments made by subsection (a) [amending this section].''

NO CHANGE IN MEDICARE'S DEFINED BENEFIT PACKAGE

Pub. L. 108–173, title II, § 241(c), Dec. 8, 2003, 117 Stat. 2221, provided that: ''Nothing in this part [probably should be this section, enacting former section 1395w–29 of this title and amending this section and sections 1395w and 1395w–23 of this title] (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].''

DETERMINATION OF PREMIUM AMOUNTS BY SECRETARY

Pub. L. 90–97, § 2, Sept. 30, 1967, 81 Stat. 249, provided that: ''Notwithstanding the provisions of section 1839(a) and (b) of the Social Security Act [42 U.S.C. 1395r(a), (b)]—

''(1) the dollar amount applicable for premiums under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for each month before April 1968 shall be $3, and

''(2) the Secretary of Health, Education, and Welfare may determine and promulgate such dollar amount for months after March 1968 and before January 1970 at any time on or before December 31, 1967.''

PERSONS ENROLLING BEFORE APRIL 1, 1968, WHO DID NOT ENROLL DURING THEIR INITIAL ENROLLMENT PERIOD

Pub. L. 90–97, § 3(b), Sept. 30, 1967, 81 Stat. 250, provided that: ''In the case of any individual who did not enroll in the insurance program established under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in his initial enrollment period, but does so enroll before April 1, 1968, the enrollment period in which he so enrolls shall, for purposes of section 1839(c) of such Act [42 U.S.C. 1395r(c)], be deemed to have closed on December 31, 1967.''

§ 1395s. Payment of premiums

(a) Deductions from section 402 or 423 monthly benefits

(1) In the case of an individual who is entitled to monthly benefits under section 402 or 423 of this title, his monthly premiums under this part shall (except as provided in subsections (b)(1) and (c)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Commissioner of Social Security shall by regulation prescribe. Such regulations shall be prescribed after consultation with the Secretary.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 402 or 423 of this title which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Commissioner of Social Security and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b) Deductions from railroad retirement annuities or pensions

(1) In the case of an individual who is entitled to receive for a month an annuity under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.] (whether or not such individual is also entitled for such month to a monthly insurance benefit under section 402 of this title), his monthly premiums under this part shall (except as provided in subsection (c)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(c) Portion of monthly premium in excess of deducted amount

If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to

the Secretary such portion of the monthly premiums for such period as he desires.

(d) Deductions from civil service retirement annuities

(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5 or any other law administered by the Director of the Office of Personnel Management providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health and Human Services to the Director of the Office of Personnel Management, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Director of the Office of Personnel Management may determine. The Director of the Office of Personnel Management shall furnish such information as the Secretary of Health and Human Services may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 or 8903a of title 5 may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other law administered by the Director of the Office of Personnel Management, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Director of the Office of Personnel Management and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(e) Manner and time of payment prescribed by Secretary

In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (c) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(f) Deposit of amounts in Treasury

Amounts paid to the Secretary under subsection (c) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(g) Premium payability period

In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

(h) Exempted monthly benefits

In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1395v of this title is applicable, subsections (a), (b), (c), and (d) of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1395v(d) of this title.

(i) Adjustments for individuals enrolled in Medicare+Choice plans

In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary premium to reflect 80 percent of any reduction elected under section 1395w–24(f)(1)(E) of this title and to reflect any credit provided under section 1395w–24(b)(1)(C)(iv)[1] of this title. To the extent to which the Secretary determines that such an adjustment is appropriate, with the concurrence of any agency responsible for the administration of such benefits, such premium adjustment may be provided directly, as an adjustment to any social security, railroad retirement, or civil service retirement benefits, or, in the case of an individual who receives medical assistance under subchapter XIX for medicare costs described in section 1396d(p)(3)(A)(ii) of this title, as an adjustment to the amount otherwise owed by the State for such medical assistance.

(Aug. 14, 1935, ch. 531, title XVIII, §1840, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 306; amended Pub. L. 89–384, §4(c), Apr. 8, 1966, 80 Stat. 106; Pub. L. 90–248, title I, §166, title IV, §403(g), Jan. 2, 1968, 81 Stat. 874, 932; Pub. L. 92–603, title II, §§201(c)(6), 263(a)–(d)(3), Oct. 30, 1972, 86 Stat. 1373, 1448, 1449; Pub. L. 93–445, title III, §306, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 98–369, div. B, title III, §2354(b)(11), title VI, §2663(j)(2)(F)(ii), July 18, 1984, 98 Stat. 1101, 1170; Pub. L. 99–53, §2(g), June 17, 1985, 99 Stat. 94; Pub. L. 100–360, title II, §212(b)(1), July 1, 1988, 102 Stat. 740; Pub. L. 100–485, title VI, §608(d)(10)(B), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 103–296, title I, §108(c)(2), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(B)(ii)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557; Pub. L. 108–173, title II, §222(*l*)(2)(B), Dec. 8, 2003, 117 Stat. 2206.)

Editorial Notes

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (b)(1), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding

[1] See References in Text note below.

section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (i), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, § 3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, § 1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

AMENDMENTS

2003—Subsec. (i). Pub. L. 108–173 inserted ''and to reflect any credit provided under section 1395w–24(b)(1)(C)(iv) of this title'' after ''section 1395w–24(f)(1)(E) of this title'' in first sentence.

2000—Subsec. (i). Pub. L. 106–554 added subsec. (i).

1994—Subsec. (a)(1). Pub. L. 103–296, § 108(c)(2)(A), substituted ''Commissioner of Social Security'' for ''Secretary'' and inserted at end ''Such regulations shall be prescribed after consultation with the Secretary.''

Subsec. (a)(2). Pub. L. 103–296, § 108(c)(2)(B), substituted ''Commissioner of Social Security'' for ''Secretary of Health and Human Services''.

1989—Subsec. (i). Pub. L. 101–234 repealed Pub. L. 100–360, § 212(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (i). Pub. L. 100–485 substituted ''Supplementary'' for ''Supplemental''.

Pub. L. 100–360 added subsec. (i) relating to transfer to flat prescription drug premiums to Federal Catastrophic Drug Insurance Trust Fund.

1985—Subsec. (d)(1). Pub. L. 99–53 inserted reference to section 8903a of title 5.

1984—Subsec. (a)(2). Pub. L. 98–369, § 2663(j)(2)(F)(ii), substituted ''Health and Human Services'' for ''Health, Education, and Welfare''.

Subsec. (d)(1). Pub. L. 98–369, § 2354(b)(11), substituted ''Director of the Office of Personnel Management'' for ''Civil Service Commission''.

Pub. L. 98–369, § 2663(j)(2)(F)(ii), substituted ''Health and Human Services'' for ''Health, Education, and Welfare''.

Subsec. (d)(2). Pub. L. 98–369, § 2354(b)(11), substituted ''Director of the Office of Personnel Management'' for ''Civil Service Commission''.

1974—Subsec. (b)(1). Pub. L. 93–445 substituted ''under the Railroad Retirement Act of 1974'' for ''or pension under the Railroad Retirement Act of 1937''.

1972—Subsec. (a)(1). Pub. L. 92–603, §§ 201(c)(6)(A), 263(a), substituted ''subsections (b)(1) and (c)'' for ''subsection (d)'' and inserted reference to section 423 of this title.

Subsec. (a)(2). Pub. L. 92–603, § 201(c)(6)(B), inserted reference to section 423 of this title.

Subsec. (b)(1). Pub. L. 92–603, § 263(b), inserted ''(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 402 of this title)'' after ''1937'' and substituted ''subsection (c)'' for ''subsection (d)''.

Subsec. (c). Pub. L. 92–603, § 263(c), struck out subsec. (c) covering individuals entitled both to monthly benefits under section 402 of this title and to an annuity or pension under Railroad Retirement Act of 1937 and redesignated former subsec. (d) as (c).

Subsec. (d). Pub. L. 92–603, § 263(c), redesignated subsec. (e) as (d). Former subsec. (d) redesignated (c).

Subsec. (e). Pub. L. 92–603, § 263(c), (d)(1), redesignated subsec. (f) as (e) and substituted ''subsection (c)'' for ''subsection (d)''. Former subsec. (e) redesignated (d).

Subsec. (f). Pub. L. 92–603, § 263(c), (d)(2), redesignated subsec. (g) as (f) and substituted ''subsections (c) or (e)'' for ''subsections (d) or (f)''. Former subsec. (f) redesignated (e) and amended.

Subsec. (g). Pub. L. 92–603, § 263(c), redesignated subsec. (h) as (g). Former subsec. (g) redesignated (f) and amended.

Subsecs. (h), (i). Pub. L. 92–603, § 263(c), (d)(3), redesignated subsec. (i) as (h) and substituted ''(c) and (d)'' for ''(c), (d), and (e)''. Former subsec. (h) redesignated (g).

1968—Subsec. (e). Pub. L. 90–248 provided for reimbursement of civil service retirement annuitants for certain premium payments under supplementary medical insurance program, and substituted ''subchapter III of chapter 83 of Title 5 or any other law'' and ''such other law'' for ''the Civil Service Retirement Act, or other Act'' and ''such other Act'', in pars. (1) and (2), respectively.

1966—Subsec. (i). Pub. L. 89–384 added subsec. (i).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, § 606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(b)(11) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(ii) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 263(f), Oct. 30, 1972, 86 Stat. 1449, provided that: ''The amendments made by this section [amending this section and sections 1395t and 1395u of this title] with respect to collection of premiums shall apply to premiums becoming due and payable after the fourth month following the month in which this Act is enacted [October 1972].''

§ 1395t. Federal Supplementary Medical Insurance Trust Fund

(a) Creation; deposits; fund transfers

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Federal Supplementary Medical Insurance Trust Fund'' (hereinafter in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, such amounts as may be deposited in, or appropriated to, such fund as provided in this part or section 9008(c)[1] of the Patient Protection and Affordable Care Act of 2009, and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1395w–116 of this title or the Transitional Assistance Account established by section 1395w–141(k)(1) of this title.

(b) Board of Trustees; composition; meetings; duties

With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the ''Board of Trustees'') composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the ''Managing Trustee''). The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[2]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) Investment of Trust Fund by Managing Trustee

It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

[1] See References in Text note below.

[2] So in original. See 2003 Amendment note below.

(d) Authority of Managing Trustee to sell obligations

Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) Interest on or proceeds from sale or redemption of obligations

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) Transfers to other Funds

There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1395gg(b) of this title. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1395gg(b) of this title.

(g) Payments from Trust Fund of amounts provided for by this part or with respect to administrative expenses

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 401(g)(1) of this title. The payments provided for under part D, other than under section 1395w–141(k)(2) of this title, shall be made from the Medicare Prescription Drug Account in the Trust Fund. The payments provided for under section 1395w–141(k)(2) of this title shall be made from the Transitional Assistance Account in the Trust Fund.

(h) Payments from Trust Fund of costs incurred by Director of Office of Personnel Management

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Director of the Office of Personnel Management in making deductions pursuant to section 1395s(d) of this title or pursuant to section 1395w–113(c)(1) or 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund). During each fiscal year, or after the close of such fiscal year, the Director of the Office of Personnel Management shall certify to the Secretary the amount of the costs the Director incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(i) Payments from Trust Fund of costs incurred by Railroad Retirement Board

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1395s(b)(1) and section 1395u(g) of this title and pursuant to sections 1395w–113(c)(1) and 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(Aug. 14, 1935, ch. 531, title XVIII, § 1841, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 308; amended Pub. L. 90–248, title I, § 169(a), Jan. 2, 1968, 81 Stat. 875; Pub. L. 92–603, title I, § 132(e), title II, § 263(d)(4), (e), Oct. 30, 1972, 86 Stat. 1361, 1449; Pub. L. 95–292, § 5, June 13, 1978, 92 Stat. 315; Pub. L. 98–21, title I, § 154(c), title III, § 341(c), Apr. 20, 1983, 97 Stat. 107, 135; Pub. L. 98–369, div. B, title III, § 2354(b)(2), (11), (12), title VI, § 2663(j)(2)(F)(iii), July 18, 1984, 98 Stat. 1100, 1101, 1170; Pub. L. 99–272, title IX, § 9213(b), Apr. 7, 1986, 100 Stat. 180; Pub. L. 100–360, title II, § 212(b)(2), (c)(4), July 1, 1988, 102 Stat. 740, 741; Pub. L. 100–647, title VIII, § 8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101–234, title II, § 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 103–296, title I, § 108(c)(3), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 108–173, title I, §§ 101(e)(3)(C), 105(d), title VIII, § 801(d)(2), title IX, § 900(e)(1)(E), Dec. 8, 2003, 117 Stat. 2151, 2166, 2359, 2371; Pub. L. 111–148, title IX, § 9008(k), Mar. 23, 2010, 124 Stat. 862.)

Editorial Notes

REFERENCES IN TEXT

Section 9008(c) of the Patient Protection and Affordable Care Act of 2009, referred to in subsec. (a), probably means section 9008(c) of Pub. L. 111–148, known as the Patient Protection and Affordable Care Act, which is set out as a note preceding section 4001 of Title 26, Internal Revenue Code.

Section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(2), is section 801(a) of Pub. L. 108–173, which is set out as a note under section 1395i of this title.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148 inserted ''or section 9008(c) of the Patient Protection and Affordable Care Act of 2009'' after ''this part''.

2003—Subsec. (a). Pub. L. 108–173, § 105(d)(1), inserted ''or the Transitional Assistance Account established by section 1395w–141(k)(1) of this title'' after ''section 1395w–116 of this title''.

Pub. L. 108–173, § 101(e)(3)(C)(i), substituted ''section 401(i)(1) of this title,'' for ''section 401(i)(1) of this title, and'' and inserted '', and such amounts as may be de-

posited in, or appropriated to, the Medicare Prescription Drug Account established by section 1395w–116 of this title'' before period at end.

Subsec. (b). Pub. L. 108–173, §900(e)(1)(E), in introductory provisions, substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration'' and, in concluding provisions, substituted ''Chief Actuary of the Centers for Medicare & Medicaid Services'' for ''Chief Actuarial Officer of the Health Care Financing Administration''.

Subsec. (b)(2). Pub. L. 108–173, §801(d)(2), inserted at end ''Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.''

Subsec. (g). Pub. L. 108–173, §105(d)(2), inserted at end ''The payments provided for under section 1395w–141(k)(2) of this title shall be made from the Transitional Assistance Account in the Trust Fund.''

Pub. L. 108–173, §101(e)(3)(C)(ii), inserted at end ''The payments provided for under part D, other than under section 1395w–141(k)(2) of this title, shall be made from the Medicare Prescription Drug Account in the Trust Fund.''

Subsec. (h). Pub. L. 108–173, §101(e)(3)(C)(iii), inserted ''or pursuant to section 1395w–113(c)(1) or 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)'' after ''section 1395s(d) of this title''.

Subsec. (i). Pub. L. 108–173, §101(e)(3)(C)(iv), inserted ''and pursuant to sections 1395w–113(c)(1) and 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)'' after ''section 1395u(g) of this title''.

1994—Subsec. (b). Pub. L. 103–296 inserted ''the Commissioner of Social Security,'' after ''composed of'' in introductory provisions.

1989—Subsecs. (a), (b). Pub. L. 101–234 repealed Pub. L. 100–360, §212(b)(2), (c)(4), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a). Pub. L. 100–360, §212(b)(2), inserted three sentences at end providing for transfer of supplemental catastrophic coverage premiums into the Federal Supplementary Medical Insurance Trust Fund.

Subsec. (b). Pub. L. 100–647 inserted after first sentence ''A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term.''

Pub. L. 100–360, §212(c)(4), inserted after sixth sentence ''Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1395t–2 of this title.''

1986—Subsec. (b). Pub. L. 99–272 struck out provision at end of penultimate sentence that the certification shall not refer to economic assumptions underlying Trustee's report.

1984—Subsec. (c). Pub. L. 98–369, §2354(b)(2), substituted ''under chapter 31 of title 31'' for ''under the Second Liberty Bond Act, as amended''.

Subsecs. (f), (g). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted ''Health and Human Services'' for ''Health, Education, and Welfare'' wherever appearing.

Subsec. (h). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted ''Health and Human Services'' for ''Health, Education, and Welfare''.

Pub. L. 98–369, §2354(b)(11), substituted ''Director of the Office of Personnel Management'' for ''Civil Service Commission'' in two places.

Pub. L. 98–369, §2354(b)(12), substituted ''the Director'' for ''it''.

Subsec. (i). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted ''Health and Human Services'' for ''Health, Education, and Welfare''.

1983—Subsec. (b). Pub. L. 98–21, §341(c)(1), substituted ''Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate'' for ''Secretary of Health, Education, and Welfare, all ex officio'' in provisions preceding par. (1).

Pub. L. 98–21, §154(c), inserted at end provision that the report referred to in par. (2) shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable, and provided further that the certification shall not refer to economic assumptions underlying the Trustee's report.

Pub. L. 98–21, §341(c)(2), inserted at end provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

1978—Subsec. (b). Pub. L. 95–292 substituted ''Administrator of the Health Care Financing Administration'' for ''Commissioner of Social Security'' in provisions preceding par. (1).

1972—Subsec. (a). Pub. L. 92–603, §132(e), inserted ''such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and'' after ''consist of'' and before ''such amounts''.

Subsec. (h). Pub. L. 92–603, §263(d)(4), substituted ''1395s(d)'' for ''1395s(e)''.

Subsec. (i). Pub. L. 92–603, §263(e), added subsec. (i).

1968—Subsec. (b)(2). Pub. L. 90–248 substituted ''April'' for ''March''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to members of Board of Trustees of Federal Supplementary Medical Insurance Trust Fund serving on such Board as members of the public on or after Nov. 10, 1988, see section 8005(b) of Pub. L. 100–647, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(b)(2), (11), (12) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(iii) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by sections 154(c) and 341(c) of Pub. L. 98–21 effective Apr. 20, 1983, see sections 154(e) and 341(d) of Pub. L. 98–21, set out as notes under section 401 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

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

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 132(e) of Pub. L. 92–603 applicable with respect to gifts and bequests received after Oct. 30, 1972, see section 132(f) of Pub. L. 92–603, set out as a note under section 401 of this title.

Amendment by section 263(d)(4), (e) of Pub. L. 92–603 with respect to collection of premiums applicable to premiums becoming due and payable after the fourth month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 263(f) of Pub. L. 92–603, set out as a note under section 1395s of this title.

DISPOSAL OF FUNDS IN FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

Pub. L. 101–234, title I, § 102(c), Dec. 13, 1989, 103 Stat. 1981, provided that: ''Any balance in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (created under section 1817A(a) of the Social Security Act [former 42 U.S.C. 1395i–1a(a)], as inserted by section 112(a) of MCCA [Pub. L. 100–360]) as of January 1, 1990, shall be transferred into the Federal Supplementary Medical Insurance Trust Fund and any amounts payable due to overpayments into such Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Notwithstanding subsec. (b)(2) of this section, the annual report of the Board of Trustees of the Trust Fund required for calendar year 1983 under this section may be filed at any time not later than forty-five days after Apr. 20, 1983, see section 154(d) of Pub. L. 98–21, set out as a note under section 401 of this title.

§§ 1395t–1, 1395t–2. Repealed. Pub. L. 101–234, title II, § 202(a), Dec. 13, 1989, 103 Stat. 1981

Section 1395t–1, act Aug. 14, 1935, ch. 531, title XVIII, § 1841A, as added July 1, 1988, Pub. L. 100–360, title II, § 212(a), 102 Stat. 739; amended Oct. 13, 1988, Pub. L. 100–485, title VI, § 608(d)(10)(A), 102 Stat. 2415, provided for the creation of the Federal Catastrophic Drug Insurance Trust Fund.

Section 1395t–2, act Aug. 14, 1935, ch. 531, title XVIII, § 1841B, as added July 1, 1988, Pub. L. 100–360, title II, § 213, formerly § 213(a), 102 Stat. 741, as redesignated Oct. 13, 1988, Pub. L. 100–485, title VI, § 608(d)(11), 102 Stat. 2415, provided for the creation of the Medicare Catastrophic Coverage Account.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF REPEAL

Repeal effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 401 of this title.

§ 1395u. Provisions relating to the administration of part B

(a) In general

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

(b) Determination of reasonable charges

(1) Repealed. Pub. L. 108–173, title IX, § 911(c)(3)(A), Dec. 8, 2003, 117 Stat. 2384.

(2)(A), (B) Repealed. Pub. L. 108–173, title IX, § 911(c)(3)(B)(i), Dec. 8, 2003, 117 Stat. 2384.

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1395x(s)(2)(K) of this title performed by a member of a team, the Secretary shall instruct medicare administrative contractors to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term ''team'' refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.

(3) The Secretary—

(A) shall take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) shall take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the medicare administrative contractor, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for services for which payment under this subchapter is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title, and (III) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this

subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the period ending 1 calendar year after the date of service;

(C) to (E) Repealed. Pub. L. 108–173, title IX, § 911(c)(3)(C)(iv), Dec. 8, 2003, 117 Stat. 2384;

(F) shall take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) shall, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1395w–4(g) of this title—

(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1395w–4(g)(2) of this title;

(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;

(H) shall implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the medicare administrative contractor, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians; [1]

(I) Repealed. Pub. L. 108–173, title IX, § 911(c)(3)(C)(vi), Dec. 8, 2003, 117 Stat. 2384;

(J), (K) Repealed. Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981;

(L) shall monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality.

In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered. In the case of physicians' services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, or (with respect to physicians' services furnished in a year after 1987) the level determined under this sentence (or under any other provision of law affecting the prevailing charge level) for the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1395x(s)(6) of this title, charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, medicare administrative contractor, or agent of the Department of Health and Human Services performing functions under this subchapter and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pur-

[1] So in original. Probably should be followed by ''and''.

suant to such third and fourth sentences for any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975, and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1395x(v)(1)(K) of this title, and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility. In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

(iv) The reasonable charge for physicians' services furnished on or after January 1, 1987, and before January 1, 1992, by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level). In the previous sentence, the term ''applicable percent'' means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1989, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.

(v) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning January 1, 1987.

(vi) Before each year (beginning with 1989), the Secretary shall establish a prevailing charge floor for primary care services (as defined in subsection (i)(4)) equal to 60 percent of the estimated average prevailing charge levels based on the best available data (determined, under the third and fourth sentences of paragraph (3) and under paragraph (4), without regard to this clause and without regard to physician specialty) for such service for all localities in the United States (weighted by the relative frequency of the service in each locality) for the year.

(vii) Beginning with 1987, the percentage increase in the MEI (as defined in subsection (i)(3)) for each year shall be the same for nonparticipating physicians as for participating physicians.

(B)(i) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services—

(I) if the physician was not a participating physician at any time during the 12-month period beginning on October 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983, and

(II) if the physician was a participating physician at any time during the 12-month period beginning on October 1, 1984, the physician's customary charges shall be determined based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985.

(iii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning January 1, 1987.

(iv) In determining the reasonable charge under paragraph (3) for physicians' services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this section

for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.

(C) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(i).

(D)(i) In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) In determining the customary charges for a physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).

(E)(i) For purposes of this part for physicians' services furnished in 1987, the percentage increase in the MEI is 3.2 percent.

(ii) For purposes of this part for physicians' services furnished in 1988, on or after April 1, the percentage increase in the MEI is—

(I) 3.6 percent for primary care services (as defined in subsection (i)(4)), and

(II) 1 percent for other physicians' services.

(iii) For purposes of this part for physicians' services furnished in 1989, the percentage increase in the MEI is—

(I) 3.0 percent for primary care services, and

(II) 1 percent for other physicians' services.

(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is—

(I) 0 percent for radiology services, for anesthesia services, and for other services specified in the list referred to in paragraph (14)(C)(i),

(II) 2 percent for other services (other than primary care services), and

(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).

(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

(I) 0 percent for services (other than primary care services), and

(II) 2 percent for primary care services (as defined in subsection (i)(4)).

(5) Repealed. Pub. L. 108–173, title IX, § 911(c)(3)(D), Dec. 8, 2003, 117 Stat. 2384.

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1395x(s)(2)(K) of this title, for such services furnished before January 1, 2022, payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1395x(aa)(2) of this title) for a continuous period beginning prior to August 5, 1997, and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1395x(aa)(2) of this title, payment may be made directly to the physician assistant, (D) payment may be made to a physician for physicians' services (and services furnished incident

to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces; and (iv) the claim form submitted to the medicare administrative contractor for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician, (E) in the case of an item or service (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by, or under arrangements made by, a skilled nursing facility to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility, (F) in the case of home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise), (G) in the case of services in a hospital or clinic to which section 1395qq(e) of this title applies, payment shall be made to such hospital or clinic, (H) in the case of services described in section 1395x(aa)(3) of this title that are furnished by a health care professional under contract with a Federally qualified health center, payment shall be made to the center. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or entity as described in subparagraph (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed, (I) in the case of home infusion therapy, payment shall be made to the qualified home infusion therapy supplier or, in the case of items and services described in clause (i) of section 1395m(u)(7)(A) of this title furnished to an individual during the period described in clause (ii) of such section, payment shall be made to the eligible home infusion therapy supplier, and (J) in the case of outpatient physical therapy services furnished by physical therapists in a health professional shortage area (as defined in section 254e(a)(1)(A) of this title), a medically underserved area (as designated pursuant to section 254b(b)(3)(A) of this title), or a rural area (as defined in section 1395ww(d)(2)(D) of this title), subparagraph (D) of this sentence shall apply to such services and therapists in the same manner as such subparagraph applies to physicians' services furnished by physicians.

(7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, the Secretary shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this subchapter, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this subchapter and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the Secretary shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the Secretary shall base payment under this subchapter on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this subchapter and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished to patients in such hospital on an assignment-related basis, the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the Secretary shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

(D)(i) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, no payment shall be made under this part for services of assistants at surgery with respect to a surgical procedure if such hospital has a training program relating to the medical specialty required for such surgical procedure and a qualified individual on the staff of the hospital is available to provide such services; except that payment may be made under this part for such services, to the extent that such payment is otherwise allowed under this paragraph, if such services, as determined under regulations of the Secretary—

(I) are required due to exceptional medical circumstances,

(II) are performed by team physicians needed to perform complex medical procedures, or

(III) constitute concurrent medical care relating to a medical condition which requires the presence of, and active care by, a physician of another specialty during surgery,

and under such other circumstances as the Secretary determines by regulation to be appropriate.

(ii) For purposes of this subparagraph, the term ''assistant at surgery'' means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(iii) The Secretary shall determine appropriate methods of reimbursement of assistants at surgery where such services are reimbursable under this part.

(8)(A)(i) The Secretary shall by regulation—

(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subchapter to payment under this part (other than to physicians' services paid under section 1395w–4 of this title) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and

(II) provide in those cases for the factors to be considered in determining an amount that is realistic and equitable.

(ii) Notwithstanding the determination made in clause (i), the Secretary may not apply factors that would increase or decrease the payment under this part during any year for any particular item or service by more than 15 percent from such payment during the preceding year except as provided in subparagraph (B).

(B) The Secretary may make a determination under this subparagraph that would result in an increase or decrease under subparagraph (A) of more than 15 percent of the payment amount for a year, but only if—

(i) the Secretary's determination takes into account the factors described in subparagraph (C) and any additional factors the Secretary determines appropriate,

(ii) the Secretary's determination takes into account the potential impacts described in subparagraph (D), and

(iii) the Secretary complies with the procedural requirements of paragraph (9).

(C) The factors described in this subparagraph are as follows:

(i) The programs established under this subchapter and subchapter XIX are the sole or primary sources of payment for an item or service.

(ii) The payment amount does not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

(iii) The payment amount for an item or service under this part is substantially higher or lower than the payment made for the item or service by other purchasers.

(D) The potential impacts of a determination under subparagraph (B) on quality, access, and beneficiary liability, including the likely effects on assignment rates and participation rates.

(9)(A) The Secretary shall consult with representatives of suppliers or other individuals who furnish an item or service before making a determination under paragraph (8)(B) with regard to that item or service.

(B) The Secretary shall publish notice of a proposed determination under paragraph (8)(B) in the Federal Register—

(i) specifying the payment amount proposed to be established with respect to an item or service,

(ii) explaining the factors and data that the Secretary took into account in determining the payment amount so specified, and

(iii) explaining the potential impacts described in paragraph (8)(D).

(C) After publication of the notice required by subparagraph (B), the Secretary shall allow not less than 60 days for public comment on the proposed determination.

(D)(i) Taking into consideration the comments made by the public, the Secretary shall publish in the Federal Register a final determination under paragraph (8)(B) with respect to the payment amount to be established with respect to the item or service.

(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination.

(10)(A)(i) In determining the reasonable charge for procedures described in subparagraph (B) and performed during the 9-month period beginning on April 1, 1988, the prevailing charge for such procedure shall be the prevailing charge otherwise recognized for such procedure for 1987—

(I) subject to clause (iii), reduced by 2.0 percent, and

(II) further reduced by the applicable percentage specified in clause (ii).

(ii) For purposes of clause (i), the applicable percentage specified in this clause is—

(I) 15 percent, in the case of a prevailing charge otherwise recognized (without regard to this paragraph and determined without regard to physician specialty) that is at least 150 percent of the weighted national average (as determined by the Secretary) of such prevailing charges for such procedure for all localities in the United States for 1987;

(II) 0 percent, in the case of a prevailing charge that does not exceed 85 percent of such weighted national average; and

(III) in the case of any other prevailing charge, a percent determined on the basis of a straight-line sliding scale, equal to 3/13 of a percentage point for each percent by which the prevailing charge exceeds 85 percent of such weighted national average.

(iii) In no case shall the reduction under clause (i) for a procedure result in a prevailing charge in a locality for 1988 which is less than 85 percent of the Secretary's estimate of the weighted national average of such prevailing charges for such procedure for all localities in the United States for 1987 (based upon the best available data and determined without regard to physician specialty) after making the reduction described in clause (i)(I).

(B) The procedures described in this subparagraph are as follows: bronchoscopy, carpal tunnel repair, cataract surgery (including subsequent insertion of an intraocular lens), coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

(C) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(D) There shall be no administrative or judicial review under section 1395ff of this title or otherwise of any determination under subparagraph (A) or under paragraph (11)(B)(ii).

(11)(A) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(i) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 1395x(r) of this title), and

(ii) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987.

(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

(C)(i) The prevailing charge level determined with respect to A-mode ophthalmic ultrasound procedures may not exceed 5 percent of the prevailing charge level established with respect to extracapsular cataract removal with lens insertion.

(ii) The reasonable charge for an intraocular lens inserted during or subsequent to cataract surgery in a physician's office may not exceed the actual acquisition cost for the lens (taking into account any discount) plus a handling fee (not to exceed 5 percent of such actual acquisition cost).

(D) In the case of a reduction in the reasonable charge for a physicians' service or item under subparagraph (B) or (C), if a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(12) Repealed. Pub. L. 105–33, title IV, § 4512(b)(2), Aug. 5, 1997, 111 Stat. 444.

(13)(A) In determining payments under section 1395*l*(*l*) of this title and section 1395w–4 of this title for anesthesia services furnished on or after January 1, 1994, the methodology for determining the base and time units used shall be the same for services furnished by physicians, for medical direction by physicians of two, three, or four certified registered nurse anesthetists, or for services furnished by a certified registered nurse anesthetist (whether or not medically directed) and shall be based on the methodology in effect, for anesthesia services furnished by physicians, as of August 10, 1993.

(B) The Secretary shall require claims for physicians' services for medical direction of nurse anesthetists during the periods in which the provisions of subparagraph (A) apply to indicate the number of such anesthetists being medically directed concurrently at any time during the procedure, the name of each nurse anesthetist being directed, and the type of procedure for which the services are provided.

(14)(A)(i) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, ⅓ of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

(ii) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990) for such service during such period.

(B) For purposes of this paragraph:

(i) The ''locally-adjusted reduced prevailing amount'' for a locality for a physicians' service is equal to the product of—

(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

(II) the adjustment factor (specified under clause (iii)) for the locality.

(ii) The ''reduced national weighted average prevailing charge'' for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

(iii) The ''adjustment factor'', for a physicians' service for a locality, is the sum of—

(I) the practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101–M, 101st Congress, 1st Session) for the service, multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

(II) 1 minus the practice expense component (percent), divided by 100.

(C) For purposes of this paragraph:

(i) The physicians' services specified in this clause are the procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

(ii) The ''national weighted average prevailing charge'' specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

(iii) The ''percentage change'' specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list referred to in clause (i).

(iv) The geographic practice cost index value specified in this clause for a locality is the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research).

(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians' services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(16)(A) In determining the reasonable charge for all physicians' services other than physicians' services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(B) For purposes of subparagraph (A), the physicians' services specified in this subparagraph are as follows:

(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in paragraph (17) and physicians' services specified in paragraph (14)(C)(i).

(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

(iii) Partial mastectomy; tendon sheath injections and small joint arthrocentesis; femoral fracture and trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; aneurysm repair; cystourethroscopy; transurethral fulguration and resection; tympanoplasty with mastoidectomy; and ophthalmoscopy.

(17) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests, tests specified in paragraph (14)(C)(i), and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.

(18)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(C) A practitioner described in this subparagraph is any of the following:

(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1395x(aa)(5) of this title).

(ii) A certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title).

(iii) A certified nurse-midwife (as defined in section 1395x(gg)(2) of this title).

(iv) A clinical social worker (as defined in section 1395x(hh)(1) of this title).

(v) A clinical psychologist (as defined by the Secretary for purposes of section 1395x(ii) of this title).

(vi) A registered dietitian or nutrition professional.

(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.

(19) For purposes of section 1395*l*(a)(1) of this title, the reasonable charge for ambulance services (as described in section 1395x(s)(7) of this title) provided during calendar year 1998 and calendar year 1999 may not exceed the reasonable charge for such services provided during the previous calendar year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced by 1.0 percentage point.

(c) Prompt payment of claims

(1) Repealed. Pub. L. 108–173, title IX, § 911(c)(4)(A), Dec. 8, 2003, 117 Stat. 2384.

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

(i) which are clean claims, and

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

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

(B) In this paragraph:

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

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

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

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians),

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians), and

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

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31 (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

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

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

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

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

(4) Neither a medicare administrative contractor nor the Secretary may impose a fee under this subchapter—

(A) for the filing of claims related to physicians' services,

(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

(C) for any appeal under this subchapter with respect to physicians' services,

(D) for applying for (or obtaining) a unique identifier under subsection (r), or

(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.

(d) to (f). Repealed. Pub. L. 108–173, title IX, § 911(c)(5), Dec. 8, 2003, 117 Stat. 2384

(g) Authority of Railroad Retirement Board to enter into contracts with medicare administrative contractors

The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a medicare administrative contractor or contractors to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 231f(d) of title 45.

(h) Participating physician or supplier; agreement with Secretary; publication of directories; availability; inclusion of program in explanation of benefits; payment of claims on assignment-related basis

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term ''participating physician or supplier'' means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

(2) The Secretary shall maintain a toll-free telephone number or numbers at which individuals enrolled under this part may obtain the names, addresses, specialty, and telephone numbers of participating physicians and suppliers and may request a copy of an appropriate directory published under paragraph (4). The Secretary shall, without charge, mail a copy of such directory upon such a request.

(3)(A) In any case in which[2] medicare administrative contractor having a contract under section 1395kk–1 of this title that provides for making payments under this part is able to develop a system for the electronic transmission to such contractor of bills for services, such contractor shall establish direct lines for the electronic receipt of claims from participating physicians and suppliers.

(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1395ss(g)(1) of this title) in which the individual is enrolled. In the case such an assignment is properly executed and a payment determination is made by a medicare administrative contractor with a contract under this section, the contractor shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into agreements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of information under this subparagraph by a medicare administrative contractor, whether electronically or otherwise, and such user fees shall be collected and retained by the contractor.

(4) At the beginning of each year the Secretary shall publish directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in paragraph (1)) for that area for that year. Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part. Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.

(5)(A) The Secretary shall promptly notify individuals enrolled under this part through an annual mailing of the participation program under this subsection and the publication and availability of the directories and shall make the appropriate area directory or directories

[2] So in original. Probably should be followed by ''a''.

available in each district and branch office of the Social Security Administration, in the offices of medicare administrative contractors, and to senior citizen organizations.

(B) The annual notice provided under subparagraph (A) shall include—

(i) a description of the participation program,

(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

(iii) an explanation of the assistance offered by medicare administrative contractors in obtaining the names of participating physicians and suppliers, and

(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1395*l*(a)(1) of this title (made other than on an assignment-related basis), shall include—

(A) a prominent reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers,

(C)(i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory, and

(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1395w–4(g) of this title, information regarding such applicable limiting charge (including information concerning the right to a refund under section 1395w–4(g)(1)(A)(iv) of this title).

(8) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1395cc(j) of this title if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this subchapter, as specified by the Secretary.

(i) Definitions

For purposes of this subchapter:

(1) A claim is considered to be paid on an ''assignment-related basis'' if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1395gg(f)(1) of this title.

(2) The term ''participating physician'' refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)); the term ''nonparticipating physician'' refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is not a participating physician; and the term ''nonparticipating supplier or other person'' means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1)).

(3) The term ''percentage increase in the MEI'' means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of subsection (b)(3)) applicable to such services furnished as of the first day of that year.

(4) The term ''primary care services'' means physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services.

(j) Monitoring of charges of nonparticipating physicians; sanctions; restitution

(1)(A) In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor the actual charges of each such physician for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills on a repeated basis for

such a service an actual charge in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(ii) Clause (i) shall not apply to services furnished after December 31, 1990.

(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's maximum allowable actual charge for that service in the previous year was—

(I) less than 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

(II) equal to, or greater than, 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

(iii) In clause (ii), the ''applicable fraction'' is—

(I) for 1987, ¼,
(II) for 1988, ⅓,
(III) for 1989, ½, and
(IV) for any subsequent year, 1.

(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the ''maximum allowable actual charge'' for 1986 is the physician's actual charge for such service furnished during such quarter.

(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1986, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the ''maximum allowable actual charge'' for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

(vi) For purposes of this subparagraph, a ''physician's actual charge'' for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.

(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined according to clauses (i) through (vi).

(viii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physician's service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise determined under this subparagraph for 1988 shall take effect on April 1, 1988.

(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.

(D)(i) If an action described in clause (ii) results in a reduction in a reasonable charge for a physicians' service or item and a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such action, the physician may not charge the individual more than 125 percent of the reduced payment allowance (as defined in clause (iii)) plus (for services or items furnished during the 12-month period (or 9-month period in the case of an action described in clause (ii)(II)) beginning on the effective date of the action) ½ of the amount by which the physician's maximum allowable actual charge for the service or item for the previous 12-month period exceeds such 125 percent level.

(ii) The first sentence of clause (i) shall apply to—

(I) an adjustment under subsection (b)(8)(B) (relating to inherent reasonableness),

(II) a reduction under subsection (b)(10)(A) or (b)(14)(A) (relating to certain overpriced procedures),

(III) a reduction under subsection (b)(11)(B) (relating to certain cataract procedures),

(IV) a prevailing charge limit established under subsection (b)(11)(C)(i) or (b)(15)(A),

(V) a reasonable charge limit established under subsection (b)(11)(C)(ii) of this section, and

(VI) an adjustment under section 1395*l*(*l*)(3)(B) of this title (relating to physician

supervision of certified registered nurse anesthetists).

(iii) In clause (i), the term ''reduced payment allowance'' means, with respect to an action—

(I) under subsection (b)(8)(B), the inherently reasonable charge established under subsection (b)(8);

(II) under subsection (b)(10)(A), (b)(11)(B), (b)(11)(C)(i), (b)(14)(A), or (b)(15)(A) or under section 1395*l*(*l*)(3)(B) of this title, the prevailing charge for the service after the action; or

(III) under subsection (b)(11)(C)(ii), the payment allowance established under such subsection.

(iv) If a physician knowingly and willfully bills in violation of clause (i) (whether or not such charge violates subparagraph (B)), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(v) Clause (i) shall not apply to items and services furnished after December 31, 1990.

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under this paragraph are—

(A) excluding a physician from participation in the programs under this chapter for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1320a–7 of this title, or

(B) civil monetary penalties and assessments, in the same manner as such penalties and assessments are authorized under section 1320a–7a(a) of this title,

or both. The provisions of section 1320a–7a of this title (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1320a–7a(a) of this title, except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).

(3)(A) The Secretary may not exclude a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

(B) The Secretary shall take into account access of beneficiaries to physicians' services for which payment may be made under this part in determining whether to bar a physician from participation under paragraph (2)(A).

(4) The Secretary may, out of any civil monetary penalty or assessment collected from a physician pursuant to this subsection, make a payment to a beneficiary enrolled under this part in the nature of restitution for amounts paid by such beneficiary to such physician which was determined to be an excess charge under paragraph (1).

(k) Sanctions for billing for services of assistant at cataract operations

(1) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1395y(a)(15) of this title, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(2) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1395y(a)(15) of this title, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(*l*) Prohibition of unassigned billing of services determined to be medically unnecessary by carrier

(1)(A) Subject to subparagraph (C), if—

(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

(ii) payment for such services is not accepted on an assignment-related basis,

(iii)(I) a medicare administrative contractor determines under this part or a quality improvement organization determines under part B of subchapter XI that payment may not be made by reason of section 1395y(a)(1) of this title because a service otherwise covered under this subchapter is not reasonable and necessary under the standards described in that section or (II) payment under this subchapter for such services is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title, and

(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual in the case described in subparagraph (A)(iii)(I) if—

(i) the physician establishes that the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1395y(a)(1) of this title, or

(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

(2) Each medicare administrative contractor with a contract in effect under this section with

respect to physicians and each quality improvement organization with a contract under part B of subchapter XI shall send any notice of denial of payment for physicians' services based on section 1395y(a)(1) of this title and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(m) Disclosure of information of unassigned claims for certain physicians' services

(1) In the case of a nonparticipating physician who—

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).

(n) Elimination of markup for certain purchased services

(1) If a physician's bill or a request for payment for services billed by a physician includes a charge for a diagnostic test described in section 1395x(s)(3) of this title (other than a clinical diagnostic laboratory test) for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares a practice personally performed or supervised the performance of the test, the amount payable with respect to the test shall be determined as follows:

(A) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indicates the amount the supplier charged the billing physician, payment for the test (less the applicable deductible and coinsurance amounts) shall be the actual acquisition costs (net of any discounts) or, if lower, the supplier's reasonable charge (or other applicable limit) for the test.

(B) If the bill or request for payment (i) does not indicate who performed the test, or (ii) indicates that the test was performed by a supplier but does not identify the supplier or include the amount charged by the supplier, no payment shall be made under this part.

(2) A physician may not bill an individual enrolled under this part—

(A) any amount other than the payment amount specified in paragraph (1)(A) and any applicable deductible and coinsurance for a diagnostic test for which payment is made pursuant to paragraph (1)(A), or

(B) any amount for a diagnostic test for which payment may not be made pursuant to paragraph (1)(B).

(3) If a physician knowingly and willfully in repeated cases bills one or more individuals in violation of paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

***(o)* Reimbursement for drugs and biologicals**

(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to the following:

(A) In the case of any of the following drugs or biologicals, 95 percent of the average wholesale price:

(i) A drug or biological furnished before January 1, 2004.

(ii) Blood clotting factors furnished during 2004.

(iii) A drug or biological furnished during 2004 that was not available for payment under this part as of April 1, 2003.

(iv) A vaccine described in subparagraph (A) or (B) of section 1395x(s)(10) of this title furnished on or after January 1, 2004.

(v) A drug or biological furnished during 2004 in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities.

(B) In the case of a drug or biological furnished during 2004 that is not described in—

(i) clause (ii), (iii), (iv), or (v) of subparagraph (A),

(ii) subparagraph (D)(i), or

(iii) subparagraph (F),

the amount determined under paragraph (4).

(C) In the case of a drug or biological that is not described in subparagraph (A)(iv), (D)(i), or (F) furnished on or after January 1, 2005 (and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017), the amount provided under section 1395w–3 of this title, section 1395w–3a of this title, section 1395w–3b of this title, or section 1395rr(b)(13) of this title, as the case may be for the drug or biological.

(D)(i) Except as provided in clause (ii), in the case of infusion drugs or biologicals furnished

through an item of durable medical equipment covered under section 1395x(n) of this title on or after January 1, 2004, and before January 1, 2017, 95 percent of the average wholesale price in effect on October 1, 2003.

(ii) In the case of such infusion drugs or biologicals furnished in a competitive acquisition area under section 1395w–3 of this title on or after January 1, 2007, and before December 13, 2016.[3], the amount provided under section 1395w–3 of this title.

(E) In the case of a drug or biological, consisting of intravenous immune globulin, furnished—

(i) in 2004, the amount of payment provided under paragraph (4); and

(ii) in 2005 and subsequent years, the amount of payment provided under section 1395w–3a of this title.

(F) In the case of blood and blood products (other than blood clotting factors), the amount of payment shall be determined in the same manner as such amount of payment was determined on October 1, 2003.

(G) In the case of inhalation drugs or biologicals furnished through durable medical equipment covered under section 1395x(n) of this title that are furnished—

(i) in 2004, the amount provided under paragraph (4) for the drug or biological; and

(ii) in 2005 and subsequent years, the amount provided under section 1395w–3a of this title for the drug or biological.

(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy. This paragraph shall not apply in the case of payment under paragraph (1)(C).

(3)(A) Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis.

(B) The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).

(4)(A) Subject to the succeeding provisions of this paragraph, the amount of payment for a drug or biological under this paragraph furnished in 2004 is equal to 85 percent of the average wholesale price (determined as of April 1, 2003) for the drug or biological.

(B) The Secretary shall substitute for the percentage under subparagraph (A) for a drug or biological the percentage that would apply to the drug or biological under the column entitled ''Average of GAO and OIG data (percent)'' in the table entitled ''Table 3.—Medicare Part B Drugs in the Most Recent GAO and OIG Studies'' published on August 20, 2003, in the Federal Register (68 Fed. Reg. 50445).

(C)(i) The Secretary may substitute for the percentage under subparagraph (A) a percentage that is based on data and information submitted by the manufacturer of the drug or biological by October 15, 2003.

(ii) The Secretary may substitute for the percentage under subparagraph (A) with respect to drugs and biologicals furnished during 2004 on or after April 1, 2004, a percentage that is based on data and information submitted by the manufacturer of the drug or biological after October 15, 2003, and before January 1, 2004.

(D) In no case may the percentage substituted under subparagraph (B) or (C) be less than 80 percent.

(5)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2005, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled ''Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost'', provide for a separate payment, to the entity which furnishes to the patient blood clotting factors, for items and services related to the furnishing of such factors in an amount that the Secretary determines to be appropriate. Such payment amount may take into account any or all of the following:

(i) The mixing (if appropriate) and delivery of factors to an individual, including special inventory management and storage requirements.

(ii) Ancillary supplies and patient training necessary for the self-administration of such factors.

(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2005, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraph (1)(C) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.

(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2006 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

(6) In the case of an immunosuppressive drug described in subparagraph (J) of section 1395x(s)(2) of this title and an oral drug described in subparagraph (Q) or (T) of such section, the Secretary shall pay to the pharmacy a supplying fee for such a drug determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts).

(7) There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (4) through (6).

(p) Requiring submission of diagnostic information

(1) Each request for payment, or bill submitted, for an item or service furnished by a physician or practitioner specified in subsection

[3] So in original. The period probably should not appear.

(b)(18)(C) for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

(2) In the case of a request for payment for an item or service furnished by a physician or practitioner specified in subsection (b)(18)(C) on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a medicare administrative contractor, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in subsection (j)(2)(A).

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1395x(s) of this title ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

(q) Anesthesia services; counting actual time units

(1)(A) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this subchapter for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:

(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

(iii) The adjusted prevailing charge conversion factor for a locality is the sum of—

(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) and (b) the geographic practice cost index value specified in subsection (b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).

(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.

(r) Establishment of physician identification system

The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this subchapter. Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.

(s) Application of fee schedule

(1)(A) Subject to paragraph (3), the Secretary may implement a statewide or other areawide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis.

(B) Any fee schedule established under this paragraph for such item or service shall be updated—

(i) for years before 2011—

(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

(II) for items and services described in paragraph (2)(D) for 2009, section 1395m(a)(14)(J) of this title shall apply under this paragraph instead of the percentage increase otherwise applicable; and

(ii) for 2011 and subsequent years—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.

(2) The items and services described in this paragraph are as follows:

(A) Medical supplies.

(B) Home dialysis supplies and equipment (as defined in section 1395rr(b)(8) of this title).

(C) Repealed. Pub. L. 108–173, title VI, § 627(b)(2), Dec. 8, 2003, 117 Stat. 2321.

(D) Parenteral and enteral nutrients, equipment, and supplies.

(E) Electromyogram devices.

(F) Salivation devices.

(G) Blood products.

(H) Transfusion medicine.

(3) In the case of items and services described in paragraph (2)(D) that are included in a competitive acquisition program in a competitive acquisition area under section 1395w–3(a) of this title—

(A) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(B) subject to section 1395m(a)(1)(G) of this title, the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise applicable under paragraph (1) for an area that is not a competitive acquisition area under section 1395w–3 of this title, and in the case of such adjustment, paragraphs (8) and (9) of subsection (b) shall not be applied.

(t) Facility provider number required on claims

(1) Each request for payment, or bill submitted, for an item or service furnished to an individual who is a resident of a skilled nursing facility for which payment may be made under this part shall include the facility's medicare provider number.

(2) Each request for payment, or bill submitted, for therapy services described in paragraph (1) or (3) of section 1395*l*(g) of this title, including services described in section 1395*l*(a)(8)(B) of this title, furnished on or after October 1, 2012, for which payment may be made under this part shall include the national provider identifier of the physician who periodically reviews the plan for such services under section 1395x(p)(2) of this title.

(u) Reporting of anemia quality indicators for cancer anti-anemia drugs

Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.

(Aug. 14, 1935, ch. 531, title XVIII, § 1842, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 309; amended Pub. L. 90–248, title I, §§ 125(a), 154(d), Jan. 2, 1968, 81 Stat. 845, 863; Pub. L. 92–603, title II, §§ 211(c)(3), 224(a), 227(e)(3), 236(a), 258(a), 262(a), 263(d)(5), 281(d), Oct. 30, 1972, 86 Stat. 1384, 1395, 1407, 1414, 1447–1449, 1455; Pub. L. 93–445, title III, § 307, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 94–182, title I, § 101(a), Dec. 31, 1975, 89 Stat. 1051; Pub. L. 94–368, §§ 2, 3(a), (b), July 16, 1976, 90 Stat. 997; Pub. L. 95–142, § 2(a)(1), Oct. 25, 1977, 91 Stat. 1175; Pub. L. 95–216, title V, § 501(b), Dec. 20, 1977, 91 Stat. 1565; Pub. L. 96–499, title IX, §§ 918(a)(1), 946(a), (b), 948(b), Dec. 5, 1980, 94 Stat. 2625, 2642, 2643; Pub. L. 97–35, title XXI, § 2142(b), Aug. 13, 1981, 95 Stat. 798; Pub. L. 97–248, title I, §§ 104(a), 113(a), 128(d)(1), Sept. 3, 1982, 96 Stat. 336, 340, 367; Pub. L. 98–369, div. B, title III, §§ 2303(e), 2306(a), (b)(1), (c), 2307(a)(1), (2), 2326(c)(2), (d)(2), 2339, 2354(b)(13), (14), title VI, 2663(j)(2)(F)(iv), July 18, 1984, 98 Stat. 1066, 1070, 1071, 1073, 1087, 1088, 1093, 1101, 1170; Pub. L. 98–617, § 3(a)(1), (b)(5), (6), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§ 9219(b)(1)(A), (2)(A), 9301(b)(1), (2), (c)(2)–(4), (d)(1)–(3), 9304(a), 9306(a), 9307(c), Apr. 7, 1986, 100 Stat. 182–188, 190, 193, 194; Pub. L. 99–509, title IX, §§ 9307(c)(2)(A), 9311(c), 9320(e)(3), 9331(a)(1)–(3), (b)(1)–(3), (c)(3)(A), 9332(a)(1), (b)(1), (2), (c)(1), (d)(1), 9333(a), (b), 9334(a), 9338(b), (c), 9341(a)(2), Oct. 21, 1986, 100 Stat. 1995, 1998, 2015, 2018–2026, 2028, 2035, 2038; Pub. L. 99–514, title XVIII, § 1895(b)(14)(A), (15), (16)(A), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 100–93, § 8(c)(2), Aug. 18, 1987, 101 Stat. 692; Pub. L. 100–203, title IV, §§ 4031(a)(2), 4035(a)(2), 4041(a)(1), (3)(A), 4042(a), (b)(1), (2)(A), (c), 4044(a), 4045(a), (c)(1), (2)(B), (D), 4046(a), 4047(a), 4048(a), (e), 4051(a), 4053(a), formerly 4052(a), 4054(a), formerly 4053(a), 4063(a), 4081(a), 4082(c), 4085(g)(1), (i)(5)–(7), (22)(C), (24)–(27), 4096(a)(1), Dec. 22, 1987, 101 Stat. 1330–76, 1330–78, 1330–83 to 1330–89, 1330–93, 1330–97, 1330–109, 1330–126, 1330–128, 1330–131, 1330–132, 1330–139, as amended Pub. L. 100–360, title IV, § 411(f)(1)(A), (2)(C), (D), (F), (3)(A), (4)(B), (7)(B), (11)(A), (14), (g)(2)(C), (i)(2), (4)(C)(vi), (j)(4)(A), July 1, 1988, 102 Stat. 776–779, 781, 783, 788, 789, 791; Pub. L. 100–360, title II, §§ 201(c), 202(c)(1), (e)(1)–(3)(A), (C), (4)(A), (5), (g), 223(b), (c), title IV, § 411(a)(3)(A), (C)(i), (f)(1)(B), (2)(A), (B), (E), (3)(B), (4)(A), (C), (5), (6)(B), (7)(A), (9), (g)(2)(A), (B), (i)(1)(A), July 1, 1988, 102 Stat. 702, 713, 716–718, 747, 768, 776–780, 783, 787; Pub. L. 100–485, title VI, § 608(d)(5)(A)–(D), (F)–(H), (17), (21)(A), (B), (D), (24)(B), Oct. 13, 1988, 102 Stat. 2414, 2418, 2420, 2421; Pub. L. 101–234, title II, § 201(a), title III, § 301(b)(2), (6), (c)(2), (d)(3), Dec. 13, 1989, 103 Stat. 1981, 1985, 1986; Pub. L. 101–239, title VI, §§ 6003(g)(3)(D)(ix), 6102(b), (e)(2)–(4), (9), 6104, 6106(a), 6107(b), 6108(a)(1), (b)(1), (2), 6114(b), (c), 6202(d)(2), Dec. 19, 1989, 103 Stat. 2153, 2184, 2187, 2188, 2208, 2210, 2212, 2213, 2218, 2234; Pub. L. 101–508, title IV, §§ 4101(a), (b)(1), 4103, 4105(a)(1), (2), (b)(1), 4106(a)(1), (b)(2), 4108(a), 4110(a), 4118(a)(1), (2), (f)(2)(A)–(C), (i)(1), (j)(2), 4155(c), Nov. 5, 1990, 104 Stat. 1388–54, 1388–58 to 1388–63, 1388–66, 1388–67, 1388–69 to 1388–71, 1388–87; Pub. L. 101–597, title IV, § 401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L.

103–66, title XIII, §§13515(a)(2), 13516(a)(2), 13517(b), 13568(a), (b), Aug. 10, 1993, 107 Stat. 583–585, 608; Pub. L. 103–432, title I, §§123(b)(1), (2)(B), (c), 125(a), (b)(1), 126(a)(1), (c), (e), (g)(9), (h)(2), 135(b)(2), 151(b)(1)(B), (2)(B), Oct. 31, 1994, 108 Stat. 4411–4416, 4423, 4434; Pub. L. 104–191, title II, §§202(b)(2), 221(b), Aug. 21, 1996, 110 Stat. 1998, 2011; Pub. L. 105–33, title IV, §§4201(c)(1), 4205(d)(3)(B), 4302(b), 4315(a), 4316(a), 4317(a), (b), 4432(b)(2), (4), 4512(b)(2), (c), 4531(a)(2), 4556(a), 4603(c)(2)(B)(i), 4611(d), Aug. 5, 1997, 111 Stat. 373, 377, 382, 390, 392, 421, 444, 450, 462, 471, 473; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §223(c), title III, §§305(a), 321(k)(4)], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, 1501A–361, 1501A–366; Pub. L. 106–554, §1(a)(6) [title I, §§105(d), 114(a), title II, §222(a), title III, §313(b)(1), (2), title IV, §432(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, 2763A–473, 2763A–487, 2763A–499, 2763A–526; Pub. L. 108–173, title III, §§302(d)(3), 303(b), (e), (g)(1), (i)(1), 305(a), title VI, §627(b)(2), title VII, §736(b)(8), (9), title IX, §§911(c), 952(a), (b), Dec. 8, 2003, 117 Stat. 2233, 2238, 2252–2255, 2321, 2356, 2383, 2427; Pub. L. 109–171, title V, §§5114(a)(2), 5202(a)(2), Feb. 8, 2006, 120 Stat. 45, 47; Pub. L. 109–432, div. B, title I, §110(a), title II, §205(b)(2), title IV, §405(c)(2)(A)(i), Dec. 20, 2006, 120 Stat. 2985, 2989, 2999; Pub. L. 110–54, §1(a), Aug. 3, 2007, 121 Stat. 551; Pub. L. 110–173, title I, §116, Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, §§137, 154(a)(2)(B), July 15, 2008, 122 Stat. 2540, 2563; Pub. L. 111–148, title III, §3401(*o*), title VI, §§6404(a)(2)(A), 6406(a), Mar. 23, 2010, 124 Stat. 488, 767, 769; Pub. L. 112–40, title II, §261(a)(3)(C), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–96, title III, §3005(c), Feb. 22, 2012, 126 Stat. 188; Pub. L. 114–255, div. A, title V, §§5004(a), (b)(2), 5012(c)(2), div. C, title XVI, §§16006(a), 16008(b)(2), Dec. 13, 2016, 130 Stat. 1190, 1191, 1202, 1328, 1329; Pub. L. 115–123, div. E, title IV, §50401(b)(1), Feb. 9, 2018, 132 Stat. 217; Pub. L. 116–260, div. CC, title IV, §403, Dec. 27, 2020, 134 Stat. 3002.)

Editorial Notes

References in Text

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (b)(14)(A)(ii), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

Section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (*o*)(5)(B), is section 303 of Pub. L. 108–173, which enacted sections 1395w–3a and 1395w–3b of this title, amended this section and sections 1395*l*, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, enacted provisions set out as notes under this section and sections 1395w–3a, 1395w–3b, and 1395w–4 of this title, and repealed provisions set out as a note under this section.

Amendments

2020—Subsec. (b)(6)(C). Pub. L. 116–260 inserted ''for such services furnished before January 1, 2022,'' after ''section 1395x(s)(2)(K) of this title,''.

2018—Subsec. (b)(6)(I). Pub. L. 115–123 inserted ''or, in the case of items and services described in clause (i) of section 1395m(u)(7)(A) of this title furnished to an individual during the period described in clause (ii) of such section, payment shall be made to the eligible home infusion therapy supplier'' after ''payment shall be made to the qualified home infusion therapy supplier''.

2016—Subsec. (b)(6)(I). Pub. L. 114–255, §5012(c)(2), added subpar. (I).

Subsec. (b)(6)(J). Pub. L. 114–255, §16006(a), added subpar. (J).

Subsec. (*o*)(1)(C). Pub. L. 114–255, §5004(a)(1), inserted ''(and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017)'' after ''2005''.

Subsec. (*o*)(1)(D)(i). Pub. L. 114–255, §5004(a)(2), substituted ''infusion drugs or biologicals'' for ''infusion drugs'' and ''2004, and before January 1, 2017'' for ''2004'' and struck out ''for such drug'' after ''average wholesale price''.

Subsec. (*o*)(1)(D)(ii). Pub. L. 114–255, §5004(a)(2)(A), (b)(2), substituted ''infusion drugs or biologicals'' for ''infusion drugs'' and ''2007, and before December 13, 2016.'' for ''2007''.

Subsec. (s)(3)(B). Pub. L. 114–255, §16008(b)(2), substituted ''subject to section 1395m(a)(1)(G) of this title, the Secretary'' for ''the Secretary''.

2012—Subsec. (t). Pub. L. 112–96 designated existing provisions as par. (1) and added par. (2).

2011—Subsec. (*l*)(1)(A)(iii)(I), (2). Pub. L. 112–40 substituted ''quality improvement organization'' for ''peer review organization''.

2010—Subsec. (b)(3). Pub. L. 111–148, §6404(a)(2)(A)(ii), at end of concluding provisions, inserted ''In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.''

Subsec. (b)(3)(B). Pub. L. 111–148, §6404(a)(2)(A)(i), substituted ''period ending 1 calendar year after the date of service'' for ''close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)'' in concluding provisions.

Subsec. (h)(9). Pub. L. 111–148, §6406(a), added par. (9).

Subsec. (s)(1). Pub. L. 111–148, §3401(*o*), designated existing provisions as subpar. (A), added subpar. (B) and concluding provisions, and struck out former second sentence, which read as follows: ''Any fee schedule established under this paragraph for such item or service shall be updated each year by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, except that for items and services described in paragraph (2)(D)—

''(A) for 2009 section 1395m(a)(14)(J)(i) of this title shall apply under this paragraph instead of the percentage increase otherwise applicable; and

''(B) for 2014, if subparagraph (A) is applied to the items and services and there has not been a payment adjustment under paragraph (3)(B) for the items and services for any previous year, the percentage increase computed under section 1395m(a)(14)(L)(i) of this title shall apply instead of the percentage increase otherwise applicable.''

2008—Subsec. (b)(6)(D)(iii). Pub. L. 110–275, §137, struck out ''(before July 1, 2008)'' after ''or are provided''.

Subsec. (s)(1). Pub. L. 110–275, §154(a)(2)(B), substituted ''except that for items and services described in paragraph (2)(D)—'' for ''except that in no event shall a fee schedule for an item described in paragraph (2)(D) be updated before 2003.'' and added subpars. (A) and (B).

2007—Subsec. (b)(6)(D)(iii). Pub. L. 110–173 substituted ''July 1, 2008'' for ''January 1, 2008''.

Pub. L. 110–54 inserted ''or are provided (before January 1, 2008) over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces'' after ''of more than 60 days''.

2006—Subsec. (b)(6)(H). Pub. L. 109–432, §§205(b)(2), 405(c)(2)(A)(i), amended directory language of Pub. L. 109–171, §5114(a)(2), identically, making technical correction. See below.

Pub. L. 109–171, §5114(a)(2), as amended by Pub. L. 109–432, §§205(b)(2), 405(c)(2)(A)(i), added subpar. (H).

Subsec. (c)(3)(B)(ii). Pub. L. 109–171, §5202(a)(2), substituted ''28 days'' for ''26 days''.

Subsec. (u). Pub. L. 109–432, §110(a), added subsec. (u).

2003—Pub. L. 108–173, §911(c)(1), substituted ''Provisions relating to the administration of part B'' for ''Use

of carriers for administration of benefits'' in section catchline.

Subsec. (a). Pub. L. 108–173, §911(c)(2), amended subsec. (a) generally. Prior to amendment, subsec. (a) authorized the Secretary to enter into contracts with carriers for the administration of benefits under this part.

Subsec. (b)(1). Pub. L. 108–173, §911(c)(3)(A), struck out par. (1), which provided that contracts with carriers under subsection (a) could be entered into without regard to section 5 of title 41 or any other provision of law requiring competitive bidding.

Subsec. (b)(2)(A), (B). Pub. L. 108–173, §911(c)(3)(B)(i), struck out subpars. (A) and (B), which conditioned entering into contract on Secretary's finding that carrier would perform obligations efficiently and effectively, provided for establishment and publication of standards and criteria for efficient and effective performance, and directed Secretary to establish standards for evaluating carriers' performance of reviews of initial carrier determinations and of fair hearings under former paragraph (3)(C).

Subsec. (b)(2)(C). Pub. L. 108–173, §911(c)(3)(B)(ii), substituted ''medicare administrative contractors'' for ''carriers''.

Subsec. (b)(2)(D), (E). Pub. L. 108–173, §911(c)(3)(B)(iii), struck out subpars. (D) and (E), which directed that carrier be subject to standards and criteria relating to the carrier's success in recovering payments for items or services for which payment has been or could be made under a primary plan and that Secretary could continue administration of claims for certain home health services through fiscal intermediaries under section 1395h of this title.

Subsec. (b)(3). Pub. L. 108–173, §911(c)(3)(C)(ix), inserted ''medicare administrative contractor,'' after ''carrier,'' in seventh sentence in concluding provisions.

Pub. L. 108–173, §911(c)(3)(C)(viii), struck out ''and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.'' before ''In determining'' in concluding provisions.

Pub. L. 108–173, §911(c)(3)(C)(i), substituted ''The Secretary'' for ''Each such contract shall provide that the carrier'' in introductory provisions.

Subsec. (b)(3)(A). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall take such action'' for ''will take such action''.

Subsec. (b)(3)(B). Pub. L. 108–173, §911(c)(3)(C)(iii), substituted ''to the policyholders and subscribers of the medicare administrative contractor'' for ''to the policyholders and subscribers of the carrier'' in introductory provisions.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall take such action'' for ''will take such action'' in introductory provisions.

Subsec. (b)(3)(C) to (E). Pub. L. 108–173, §911(c)(3)(C)(iv), struck out subpars. (C) to (E), which directed that each contract provide that the carrier would establish and maintain procedures for a fair hearing in any case where the amount in controversy was between $100 and $500, that the carrier would furnish to the Secretary such information and reports as he would find necessary in performing his functions under this part, and that the carrier would maintain such records and afford such access thereto as the Secretary would find necessary to assure the correctness and verification of the information and reports under former subpar. (D) and otherwise to carry out the purposes of this part.

Subsec. (b)(3)(F). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall take such action'' for ''will take such action''.

Subsec. (b)(3)(G). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall, for a service'' for ''will, for a service'' in introductory provisions.

Subsec. (b)(3)(H). Pub. L. 108–173, §911(c)(3)(C)(v)(I), struck out ''if it makes determinations or payments with respect to physicians' services,'' before ''shall implement'' in introductory provisions.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall implement'' for ''will implement'' in introductory provisions.

Subsec. (b)(3)(H)(i). Pub. L. 108–173, §911(c)(3)(C)(v)(II), substituted ''medicare administrative contractor'' for ''carrier''.

Subsec. (b)(3)(I). Pub. L. 108–173, §911(c)(3)(C)(vi), struck out subpar. (I), which directed that each contract would require the carrier to submit annual reports to the Secretary describing steps taken to recover payments made under this part for items or services for which payment had been or could have been made under a primary plan.

Subsec. (b)(3)(L). Pub. L. 108–173, §911(c)(3)(C)(vii), substituted period for semicolon at end.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted ''shall monitor'' for ''will monitor''.

Subsec. (b)(5). Pub. L. 108–173, §911(c)(3)(D), struck out par. (5), which provided that each contract under this section would be for a term of at least one year and could be made automatically renewable and authorized Secretary to terminate any contract where carrier had failed substantially to carry out the contract or was carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

Subsec. (b)(6). Pub. L. 108–173, §952(b), substituted ''except to an employer or entity as described in subparagraph (A)'' for ''except to an employer or facility as described in clause (A)'' in second sentence.

Subsec. (b)(6)(A)(ii). Pub. L. 108–173, §952(a), added cl. (ii) and struck out former cl. (ii) which read as follows: ''(where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,''.

Subsec. (b)(6)(D)(iv). Pub. L. 108–173, §911(c)(3)(E), substituted ''medicare administrative contractor'' for ''carrier''.

Subsec. (b)(7). Pub. L. 108–173, §911(c)(3)(F), substituted ''the Secretary'' for ''the carrier'' in introductory provisions of subpar. (A), before ''shall take into account'' in subpar. (B)(i), in introductory provisions of subpar. (B)(ii), and before ''shall provide'' in subpar. (C).

Subsec. (c)(1). Pub. L. 108–173, §911(c)(4)(A), struck out par. (1), which provided that any contract entered into with a carrier under this section would provide for advances of funds for the making of payments and for payment for necessary and proper cost of administration, and directed the Secretary to cause to have published in the Federal Register, by not later than Sept. 1 each year, data, standards, and methodology to be used to establish budgets for carriers and to cause to be published in the Federal Register for public comment, at least 90 days before Sept. 1, the data, standards, and methodology proposed to be used.

Subsec. (c)(2)(A). Pub. L. 108–173, §911(c)(4)(B), substituted ''contract under section 1395kk–1 of this title that provides for making payments under this part'' for ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B) of this section,'' in introductory provisions.

Subsec. (c)(2)(B)(ii)(III). Pub. L. 108–173, §736(b)(8)(A), struck out ''and'' at end.

Subsec. (c)(2)(B)(ii)(IV). Pub. L. 108–173, §736(b)(8)(B), substituted '', and'' for period at end.

Subsec. (c)(3)(A). Pub. L. 108–173, §911(c)(4)(C), substituted ''section 1395kk–1(a)(3)(B) of this title'' for ''subsection (a)(1)(B) of this section''.

Subsec. (c)(4). Pub. L. 108–173, §911(c)(4)(D), substituted ''medicare administrative contractor'' for ''carrier'' in introductory provisions.

Subsec. (c)(5), (6). Pub. L. 108–173, §911(c)(4)(E), struck out pars. (5) and (6), which provided that each contract would require the carrier to meet criteria to measure the timeliness of responses to requests for payment of items described in section 1395m(a)(15)(C) of this title and prohibited any carrier from carrying out any activity pursuant to a contract under the Medicare Integrity Program under section 1395ddd of this title.

Subsec. (d) to (f). Pub. L. 108–173, §911(c)(5), struck out subsecs. (d) to (f), which provided that contracts under this section could require surety bonds and that certifying or disbursing officers or carriers would not be liable with respect to payments in the absence of gross negligence or intent to defraud and defined ''carrier'' for purposes of this part.

Subsec. (g). Pub. L. 108–173, §911(c)(6), substituted ''medicare administrative contractor or contractors'' for ''carrier or carriers''.

Subsec. (h)(2). Pub. L. 108–173, §911(c)(7)(A), substituted ''The Secretary'' for ''Each carrier having an agreement with the Secretary under subsection (a) of this section'' in first sentence and for ''Each such carrier'' in last sentence.

Subsec. (h)(3)(A). Pub. L. 108–173, §911(c)(7)(B)(ii), which directed substitution of ''such contractor'' for ''such carrier'', was executed by making the substitution in two places to reflect the probable intent of Congress.

Pub. L. 108–173, §911(c)(7)(B)(i), substituted ''medicare administrative contractor having a contract under section 1395kk–1 of this title that provides for making payments under this part'' for ''a carrier having an agreement with the Secretary under subsection (a) of this section''.

Subsec. (h)(3)(B). Pub. L. 108–173, §911(c)(7)(C), substituted ''a medicare administrative contractor'' for ''a carrier'' in two places and ''the contractor'' for ''the carrier'' in two places.

Subsec. (h)(5)(A), (B)(iii). Pub. L. 108–173, §911(c)(7)(D), substituted ''medicare administrative contractors'' for ''carriers''.

Subsec. (i)(2). Pub. L. 108–173, §736(b)(9), substituted ''services, to a physician'' for ''services, a physician''.

Subsec. (*l*)(1)(A)(iii), (2). Pub. L. 108–173, §911(c)(8), substituted ''medicare administrative contractor'' for ''carrier''.

Subsec. (*o*)(1). Pub. L. 108–173, §303(b)(1), substituted ''equal to the following:'' for ''equal to 95 percent of the average wholesale price.'' and added subpars. (A) to (G).

Subsec. (*o*)(1)(G). Pub. L. 108–173, §305(a), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: ''The provisions of subparagraphs (A) through (F) of this paragraph shall not apply to an inhalation drug or biological furnished through durable medical equipment covered under section 1395x(n) of this title.''

Subsec. (*o*)(2). Pub. L. 108–173, §303(i)(1), inserted at end ''This paragraph shall not apply in the case of payment under paragraph (1)(C).''

Subsec. (*o*)(4). Pub. L. 108–173, §303(b)(2), added par. (4).

Subsec. (*o*)(5), (6). Pub. L. 108–173, §303(e), added pars. (5) and (6).

Subsec. (*o*)(7). Pub. L. 108–173, §303(g)(1), added par. (7).

Subsec. (p)(3)(A). Pub. L. 108–173, §911(c)(9), substituted ''medicare administrative contractor'' for ''carrier''.

Subsec. (q)(1)(A). Pub. L. 108–173, §911(c)(10), struck out ''carrier'' before ''localities''.

Subsec. (s)(1). Pub. L. 108–173, §302(d)(3)(A), substituted ''Subject to paragraph (3), the Secretary'' for ''The Secretary''.

Subsec. (s)(2)(C). Pub. L. 108–173, §627(b)(2), struck out subpar. (C) which read as follows: ''Therapeutic shoes.''

Subsec. (s)(3). Pub. L. 108–173, §302(d)(3)(B), added par. (3).

2000—Subsec. (b)(6)(C). Pub. L. 106–554, §1(a)(6) [title II, §222(a)], struck out ''for such services provided before January 1, 2003,'' before ''payment may be made'' and substituted comma for semicolon at end.

Subsec. (b)(6)(E). Pub. L. 106–554, §1(a)(6) [title III, §313(b)(1)], inserted ''by, or under arrangements made by, a skilled nursing facility'' before ''to an individual who'' and struck out ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations)'' before '', payment shall be made'' and ''(without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise)'' after ''to the facility''.

Subsec. (b)(6)(G). Pub. L. 106–554, §1(a)(6) [title IV, §432(b)(2)], added subpar. (G).

Subsec. (b)(18)(C)(vi). Pub. L. 106–554, §1(a)(6) [title I, §105(d)], added cl. (vi).

Subsec. (*o*)(3). Pub. L. 106–554, §1(a)(6) [title I, §114(a)], added par. (3).

Subsec. (t). Pub. L. 106–554, §1(a)(6) [title III, §313(b)(2)], struck out ''by a physician'' before ''to an individual'' and ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations),'' before ''for which payment may be made''.

1999—Subsec. (b)(6)(F). Pub. L. 106–113, §1000(a)(6) [title III, §305(a)], inserted ''(including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section)'' after ''home health services''.

Subsec. (b)(8)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title II, §223(c)], substituted ''the application of this subchapter to payment under this part'' for ''the application of this part''.

Subsec. (s)(2)(E). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(4)], inserted period at end.

1997—Subsec. (b)(2)(E). Pub. L. 105–33, §4611(d), added subpar. (E).

Subsec. (b)(6). Pub. L. 105–33, §4512(c), inserted at end ''For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''

Subsec. (b)(6)(A)(ii). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (b)(6)(C). Pub. L. 105–33, §4205(d)(3)(B), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''in the case of services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title payment shall be made to the employer of the physician assistant or nurse practitioner involved, and''.

Subsec. (b)(6)(E). Pub. L. 105–33, §4432(b)(2), added subpar. (E).

Subsec. (b)(6)(F). Pub. L. 105–33, §4603(c)(2)(B)(i), added subpar. (F).

Subsec. (b)(8), (9). Pub. L. 105–33, §4316(a), amended pars. (8) and (9) generally. Prior to amendment, par. (8) related to determination of reasonable charges for physician services, including factors to be considered, provision for increase or decrease of charge, consideration of resource costs, accounting for regional differences in prevailing charges, and impact of changes in reasonable charges, and par. (9) related to notice of proposed reasonable charges to be published in Federal Register, provision for comments on proposed changes, and publication of final determinations with respect to change in reasonable charges.

Subsec. (b)(12). Pub. L. 105–33, §4512(b)(2), struck out par. (12) which read as follows:

''(12)(A) With respect to services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title (relating to a physician assistants and nurse practitioners)—

''(i) payment under this part may only be made on an assignment-related basis; and

''(ii) the prevailing charges determined under paragraph (3) shall not exceed—

''(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

''(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services (or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1395w–4 of this title) performed by physicians who are not specialists.

''(B) In subparagraph (A)(ii)(II), the term 'applicable percentage' means—

''(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

''(ii) 85 percent in the case of other services.''

Subsec. (b)(19). Pub. L. 105–33, §4531(a)(2), added par. (19).

Subsec. (h)(8). Pub. L. 105–33, §4302(b), added par. (8).

Subsec. (*o*). Pub. L. 105–33, §4556(a), added subsec. (*o*).

Subsec. (p)(1), (2). Pub. L. 105–33, §4317(a), inserted ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

Subsec. (p)(4). Pub. L. 105–33, §4317(b), added par. (4).

Subsec. (s). Pub. L. 105–33, §4315(a), added subsec. (s).

Subsec. (t). Pub. L. 105–33, §4432(b)(4), added subsec. (t).

1996—Subsec. (c)(6). Pub. L. 104–191, §202(b)(2), added par. (6).

Subsec. (r). Pub. L. 104–191, §221(b), inserted at end ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''

1994—Subsec. (b)(2)(A). Pub. L. 103–432, §126(g)(9), made technical amendment to directory language of Pub. L. 101–508, §4118(j)(2). See 1990 Amendment note below.

Subsec. (b)(2)(D). Pub. L. 103–432, §151(b)(2)(B), added subpar. (D).

Subsec. (b)(3)(G). Pub. L. 103–432, §151(b)(1)(B)(i), which directed striking out ''and'' at end of subpar. (G), could not be executed because ''and'' did not appear at end of subpar. (G) subsequent to amendment by Pub. L. 103–432, §123(c)(2). See below.

Pub. L. 103–432, §123(c)(2), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: ''will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's limiting charges established under section 1395w–4(g)(2) of this title for the year for the physicians' services mostly commonly furnished by that physician; and''.

Subsec. (b)(3)(H). Pub. L. 103–432, §151(b)(1)(B)(ii), which directed striking out ''and'' at end of subpar. (H), could not be executed because ''and'' does not appear at end.

Subsec. (b)(3)(I). Pub. L. 103–432, §151(b)(1)(B)(iii), added subpar. (I).

Subsec. (b)(6)(D). Pub. L. 103–432, §125(b)(1), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: ''payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavailable to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r) of this section) and indicates that the claim is for such a 'covered visit service (and related services)', and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days.''

Subsec. (b)(12)(C). Pub. L. 103–432, §123(b)(2)(B), struck out subpar. (C). Prior to amendment, subpar. (C) read as follows: ''Except for deductible and coinsurance amounts applicable under section 1395*l* of this title, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title in violation of subparagraph (A)(i) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (b)(16)(B)(iii). Pub. L. 103–432, §126(a)(1), struck out '', simple and subcutaneous'' after ''Partial'', substituted ''injections and small joint'' for ''injections; small joint'' and ''femoral fracture and'' for ''femoral fracture treatments;'', struck out ''lobectomy;'' after ''thoracostomy;'' and ''enterectomy; colectomy; cholecystectomy;'' after ''aneurysm repair;'', substituted ''fulguration and resection'' for ''fulguration; transurerethral resection'', and struck out ''sacral laminectomy;'' before ''tympanoplasty''.

Subsec. (b)(17). Pub. L. 103–432, §126(e), redesignated par. (18), relating to payment for technical component of diagnostic tests, as (17) and inserted '', tests specified in paragraph (14)(C)(i),'' after ''diagnostic laboratory tests''.

Subsec. (b)(18). Pub. L. 103–432, §126(e), redesignated par. (18), relating to payment for technical component of diagnostic tests, as (17).

Pub. L. 103–432, §123(b)(1), added par. (18), relating to payment for service furnished by a practitioner described in subpar. (C).

Subsec. (c)(1). Pub. L. 103–432, §126(h)(2), struck out subpar. (A) designation before ''Any contract entered'' and struck out subpar. (B) which read as follows: ''Of the amounts appropriated for administrative activities to carry out this part, the Secretary shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under this section, to reward carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians or in increasing the proportion of total payments for physicians' services which are payments for such services rendered by participating physicians.''

Subsec. (c)(4). Pub. L. 103–432, §125(a), added par. (4).

Subsec. (c)(5). Pub. L. 103–432, §135(b)(2), added par. (5).

Subsec. (h)(7)(C). Pub. L. 103–432, §123(c)(1)(B), struck out ''shall include'' before cl. (i).

Subsec. (h)(7)(D). Pub. L. 103–432, §123(c)(1)(A), (C), (D), added subpar. (D).

Subsec. (q)(1). Pub. L. 103–432, §126(c)(1), made technical amendment to Pub. L. 101–508, §4103(a). See 1990 Amendment note below.

Subsec. (q)(1)(B). Pub. L. 103–432, §126(c)(2)(A), substituted ''shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:'' for ''shall be determined as follows:'' in introductory provisions.

Subsec. (q)(1)(B)(iii). Pub. L. 103–432, §126(c)(2)(B), substituted ''The adjusted prevailing charge conversion factor for'' for ''Subject to clause (iv), the prevailing charge conversion factor to be applied in''.

1993—Subsec. (b)(4)(F). Pub. L. 103–66, §13515(a)(2), struck out subpar. (F) which related to prevailing charge or fee schedule amount in case of professional services of health care practitioner (other than primary care services and other than services furnished in rural area designated as health professional shortage area) furnished during practitioner's first through fourth years of practice.

Subsec. (b)(13)(A). Pub. L. 103–66, §13516(a)(2)(A), added subpar. (A) and struck out former subpar. (A) which read as follows: ''In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after April 1, 1988, and before January 1, 1996, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent procedure (other than cataract surgery or an iridectomy) shall be reduced by—

''(i) 10 percent, in the case of medical direction of 2 nurse anesthetists concurrently,

''(ii) 25 percent, in the case of medical direction of 3 nurse anesthetists concurrently, and

''(iii) 40 percent, in the case of medical direction of 4 nurse anesthetists concurrently.''

Subsec. (b)(13)(B), (C). Pub. L. 103–66, §13516(a)(2), redesignated subpar. (C) as (B), substituted ''subpara-

graph (A)'' for ''subparagraph (A) or (B)'', and struck out former subpar. (B) which read as follows: ''In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after January 1, 1989, and before January 1, 1996, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent cataract surgery or iridectomy procedure shall be reduced by 10 percent.''

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

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

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

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

Subsec. (i)(2). Pub. L. 103–66, §13517(b), substituted ''; the term'' for '', and the term'' and inserted before period at end ''; and the term 'nonparticipating supplier or other person' means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1))''.

1990—Subsec. (b)(2)(A). Pub. L. 101–508, §4118(j)(2), as amended by Pub. L. 103–432, §126(g)(9), substituted ''section 1395w–1(e)(2)'' for ''section 1395w–1(f)(2)''.

Subsec. (b)(3)(G). Pub. L. 101–508, §4118(f)(2)(B), substituted ''section 1395w–4(g)(2) of this title'' for ''subsection (j)(1)(C) of this section''.

Subsec. (b)(4)(A)(vi). Pub. L. 101–508, §4105(b)(1), substituted ''60 percent'' for ''50 percent''.

Subsec. (b)(4)(B)(iv). Pub. L. 101–508, §4105(a)(2), added cl. (iv).

Subsec. (b)(4)(E)(iv)(I). Pub. L. 101–508, §4118(a)(2), substituted ''the list referred to in paragraph (14)(C)(i)'' for ''Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress''.

Subsec. (b)(4)(E)(v). Pub. L. 101–508, §4105(a)(1), added cl. (v).

Subsec. (b)(4)(F). Pub. L. 101–508, §4106(a)(1), amended subpar. (F) generally. Prior to amendment, subpar. (F) read as follows: ''In determining the customary charges for physicians' services furnished during a calendar year (other than primary care services and other than services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 254e(a)(1)(A) of this title, as a health manpower shortage area) for which adequate actual charge data are not available because a physician has not yet been in practice for a sufficient period of time, the Secretary shall set a customary charge at a level no higher than 80 percent of the prevailing charge for a service. For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service.''

Subsec. (b)(4)(F)(i). Pub. L. 101–597 substituted ''health professional shortage area'' for ''health manpower shortage area''.

Pub. L. 101–508, §4106(b)(2)(A), (B), substituted ''professional services'' for ''physicians' services and professional services'' and ''practitioner's first'' for ''physician's or practitioner's first''.

Subsec. (b)(4)(F)(ii)(II). Pub. L. 101–508, §4106(b)(2)(C), substituted ''practitioner'' for ''physician or practitioner'' in two places.

Subsec. (b)(6)(C). Pub. L. 101–508, §4155(c), substituted ''clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)'' for ''section 1395x(s)(2)(K)''.

Subsec. (b)(6)(D). Pub. L. 101–508, §4110(a), added subpar. (D).

Subsec. (b)(12)(A). Pub. L. 101–508, §4155(c), substituted ''clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)'' for ''section 1395x(s)(2)(K)'' in introductory provisions.

Subsec. (b)(12)(A)(ii)(II). Pub. L. 101–508, §4118(f)(2)(C), struck out '', as the case may be'' after ''section 1395w–4 of this title''.

Pub. L. 101–508, §4118(f)(2)(A), made technical correction to Pub. L. 101–239, §6102(e)(4). See 1989 Amendment note below.

Subsec. (b)(12)(C). Pub. L. 101–508, §4155(c), substituted ''clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)'' for ''section 1395x(s)(2)(K)''.

Subsec. (b)(13)(A), (B). Pub. L. 101–508, §4103(b), substituted ''1996'' for ''1991''.

Subsec. (b)(14)(A). Pub. L. 101–508, §4101(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(14)(B)(iii)(I). Pub. L. 101–508, §4118(a)(1)(A), which directed amendment of subcl. (I) by substituting ''practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101–M, 101st Congress, 1st Session) for the service'' for ''practice expense ratio for the service (specified in table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))'', was executed by making the substitution for ''practice expense ratio for the service (specified in Table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))'' to reflect the probable intent of Congress.

Subsec. (b)(14)(B)(iii)(II). Pub. L. 101–508, §4118(a)(1)(B), substituted ''practice expense component (percent), divided by 100'' for ''practice expense ratio''.

Subsec. (b)(14)(C)(i). Pub. L. 101–508, §4118(a)(1)(C), substituted ''procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission'' for ''physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress,''.

Subsec. (b)(14)(C)(iii). Pub. L. 101–508, §4118(a)(1)(D), which directed amendment of cl. (iii) by substituting ''The 'percentage change' specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list'' for ''The 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in table #2 in the Joint Explanatory Statement'', was executed by making the substitution for ''The 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in Table #2 in the Joint Explanatory Statement'' to reflect the probable intent of Congress.

Subsec. (b)(14)(C)(iv). Pub. L. 101–508, §4118(a)(1)(E), which directed amendment of cl. (iv) by substituting ''the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)'' for ''such value specified for the locality in table #3 in the Joint Explanatory Statement referred to in clause (i)'', was executed by making the substitution for ''such value specified for the locality in Table #3 in the Joint Explanatory Statement referred to in clause (i)'' to reflect the probable intent of Congress.

Subsec. (b)(16). Pub. L. 101–508, §4101(b), added par. (16).

Subsec. (b)(18). Pub. L. 101–508, §4108(a), added par. (18).

Subsec. (q)(1). Pub. L. 101–508, §4103(a), as amended by Pub. L. 103–432, §126(c)(1), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (r). Pub. L. 101–508, §4118(i)(1), added subsec. (r).

1989—Subsec. (b)(2)(A). Pub. L. 101–239, § 6202(d)(2), inserted at end ''The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1395hh of this title, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1395y(b) of this title may apply.''

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(e)(3)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(2)(C). Pub. L. 101–239, § 6114(c)(2), added subpar. (C).

Subsec. (b)(3)(G). Pub. L. 101–239, § 6102(e)(2), substituted ''limiting charges established under subsection (j)(1)(C) of this section'' for ''maximum allowable actual charges (established under subsection (j)(1)(C) of this section)''.

Subsec. (b)(3)(I) to (K). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, §§ 201(c), 202(e)(2), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (b)(3)(L). Pub. L. 101–239, § 6102(b), added subpar. (L).

Subsec. (b)(4)(A)(iv). Pub. L. 101–239, § 6102(e)(3), inserted ''and before January 1, 1992,'' after ''January 1, 1987,''.

Subsec. (b)(4)(E)(iv). Pub. L. 101–239, § 6107(b), added cl. (iv).

Subsec. (b)(4)(F). Pub. L. 101–239, § 6108(a)(1), inserted ''furnished during a calendar year'' after ''physicians' services'' and inserted at end ''For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service.''

Subsec. (b)(6)(A)(ii). Pub. L. 101–239, § 6003(g)(3)(D)(ix), inserted ''rural primary care hospital,'' after ''hospital,''.

Subsec. (b)(6)(C). Pub. L. 101–239, § 6114(c)(1), inserted ''or nurse practitioner'' after ''physician assistant''.

Subsec. (b)(12)(A). Pub. L. 101–239, § 6114(b), substituted ''physician assistants and nurse practitioners'' for ''physician assistant acting under the supervision of a physician'' in introductory provisions.

Subsec. (b)(12)(A)(ii)(II). Pub. L. 101–239, § 6102(e)(4), as amended by Pub. L. 101–508, § 4118(f)(2)(A), inserted ''(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1395w–4 of this title, as the case may be)'' after ''prevailing charge rate determined for such services''.

Subsec. (b)(14). Pub. L. 101–239, § 6104(a), added par. (14).

Subsec. (b)(15). Pub. L. 101–239, § 6108(b)(1), added par. (15).

Subsecs. (c)(1)(A), (2)(A), (3)(A), (4), (f)(3), (h)(1), (2), (4). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(c)(1)(A), (B), (e)(1), (3)(A), (4)(A), (5), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (j)(1)(B)(ii). Pub. L. 101–239, § 6102(e)(9), substituted ''December 31, 1990.'' for ''the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title.''

Subsec. (j)(1)(C)(vii). Pub. L. 101–234, § 301(b)(2), (c)(2), amended cl. (vii) identically, substituting ''according'' for ''accordingly''.

Subsec. (j)(1)(D)(ii)(II). Pub. L. 101–239, § 6104(b)(1), inserted ''or (b)(14)(A)'' after ''(b)(10)(A)''.

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 101–239, § 6108(b)(2)(A), inserted ''or (b)(15)(A)'' after ''subsection (b)(11)(C)(i)''.

Subsec. (j)(1)(D)(iii)(II). Pub. L. 101–239, § 6108(b)(2)(B), substituted ''(b)(14)(A), or (b)(15)(A)'' for ''or (b)(14)(A)''.

Pub. L. 101–239, § 6104(b)(2), substituted ''(b)(11)(C)(i), or (b)(14)(A)'' for ''or (b)(11)(C)(i)''.

Subsec. (j)(1)(D)(v). Pub. L. 101–239, § 6102(e)(9), substituted ''December 31, 1990.'' for ''the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title.''

Subsec. (j)(2). Pub. L. 101–234, § 301(b)(6), (d)(3), which directed identical amendments to subsec. (j)(2) by substituting ''subsections'' for ''paragraphs'' in subpar. (B) as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987 [probably meaning section 8(c)(2)(A) of Pub. L. 100–93, the Medicare and Medicaid Patient and Program Protection Act of 1987, which amended subpar. (A) of subsec. (j)(2), generally] could not be executed because the word ''paragraphs'' did not appear.

Subsec. (*o*). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(c)(1)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (q). Pub. L. 101–239, § 6106(a), added subsec. (q).

1988—Subsec. (b)(2). Pub. L. 100–360, § 411(i)(2), amended Pub. L. 100–203, § 4082(c), see 1987 Amendment note below.

Subsec. (b)(2)(A). Pub. L. 100–485, § 608(d)(5)(G), inserted '', including claims processing functions'' after ''and related functions'' in last sentence.

Pub. L. 100–360, § 411(f)(1)(B), inserted reference to section 1395w–1(f)(2) of this title in third sentence.

Pub. L. 100–360, § 202(e)(3)(C), as amended by Pub. L. 100–485, § 608(d)(5)(F), inserted at end ''With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (*o*)(4) of this section, the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.''

Subsec. (b)(3). Pub. L. 100–360, § 411(i)(4)(C)(vi), added Pub. L. 100–203, § 4085(i)(24), see 1987 Amendment note below.

Pub. L. 100–360, § 411(f)(4)(B)(ii), added Pub. L. 100–203, § 4045(c)(2)(D), see 1987 Amendment note below.

Pub. L. 100–360, § 411(f)(11)(A), (14), renumbered and amended Pub. L. 100–203, § 4053(a), see 1987 Amendment note below.

Subsec. (b)(3)(B)(ii). Pub. L. 100–360, § 411(j)(4)(A), made technical correction to directory language of Pub. L. 100–203, § 4096(a)(1)(A), see 1987 Amendment note below.

Subsec. (b)(3)(I). Pub. L. 100–360, § 201(c), added subpar. (I) requiring notice that an individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year.

Subsec. (b)(3)(J). Pub. L. 100–360, § 202(e)(2), added subpar. (J) relating to requirements for determinations or payments with respect to covered outpatient drugs, to receive information and respond to requests by participating pharmacies.

Subsec. (b)(3)(K). Pub. L. 100–485, § 608(d)(5)(C), inserted '', including claims processing functions,'' after ''and for related functions''.

Pub. L. 100–360, § 202(e)(2), added subpar. (K) requiring contracts with organizations described in subsection (f)(3) of this section to implement and operate the electronic system established under subsection (*o*)(4) of this section for covered outpatient drugs.

Subsec. (b)(4)(A)(iv). Pub. L. 100–360, § 411(f)(2)(F)(i), as amended by Pub. L. 100–485, § 608(d)(21)(B), redesignated and amended Pub. L. 100–203, § 4042(c)(1), see 1987 Amendment note below.

Subsec. (b)(4)(A)(iv)(II). Pub. L. 100–360, § 411(f)(2)(E), substituted ''before January 1, 1989'' for ''before January 1, 1988''.

Subsec. (b)(4)(A)(vi). Pub. L. 100–360, § 411(f)(3)(A), made technical amendment to directory language of Pub. L. 100–203, § 4044(a), see 1987 Amendment note below.

Pub. L. 100–360, § 411(f)(3)(B), substituted ''subsection (i)(4)'' for ''subparagraph (E)(iii)'' and ''the estimated

average prevailing charge levels based on the best available data'' for ''the average of the prevailing charge levels'' and struck out ''for participating physicians'' before ''under the third''.

Subsec. (b)(4)(A)(vii). Pub. L. 100–360, §411(f)(2)(D), added Pub. L. 100–203, §4042(b)(2)(A), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(3)(A), made technical amendment to directory language of Pub. L. 100–203, §4044(a), see 1987 Amendment note below.

Subsec. (b)(4)(E). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(C), (D), see 1987 Amendment notes below.

Subsec. (b)(4)(F). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(D), see 1987 Amendment note below.

Subsec. (b)(4)(F)(ii)(I). Pub. L. 100–360, §411(f)(2)(B), substituted ''subsection (i)(4)'' for ''subparagraph (E)(iii)''.

Subsec. (b)(4)(F)(iii). Pub. L. 100–360, §411(f)(2)(A), substituted ''services,'' for ''services;'' in subcl. (I) and ''physicians' '' for ''physician's'' in subcl. (II).

Subsec. (b)(4)(G). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(D), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(6)(B), substituted ''other than primary care services'' for ''other primary care services'' and struck out ''(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))'' after ''the prevailing charge''.

Subsec. (b)(7)(B)(iii). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(C), see 1987 Amendment note below.

Subsec. (b)(10)(A)(i). Pub. L. 100–360, §411(f)(4)(A)(i), struck out ''under paragraph (3)'' after ''reasonable charge'', substituted ''subparagraph (B)'' for ''subparagraph (C)'', and struck out ''for participating and nonparticipating physicians'' after ''charge for such procedure''.

Subsec. (b)(10)(A)(iii). Pub. L. 100–360, §411(f)(4)(A)(ii), substituted ''clause (i)(I)'' for ''clause (i)(II)''.

Subsec. (b)(10)(B). Pub. L. 100–360, §411(f)(4)(A)(iii), inserted ''(including subsequent insertion of an intraocular lens)'' after ''cataract surgery''.

Subsec. (b)(10)(D). Pub. L. 100–360, §411(f)(4)(A)(iv), substituted ''under section 1395ff'' for ''section 1395ff''.

Subsec. (b)(11)(B)(i). Pub. L. 100–360, §411(f)(4)(B)(i), amended Pub. L. 100–203, §4045(c)(2)(B), see 1987 Amendment note below.

Subsec. (b)(11)(C)(i). Pub. L. 100–360, §411(f)(5)(A), substituted ''insertion'' for ''implantation''.

Subsec. (b)(11)(C)(ii). Pub. L. 100–360, §411(g)(2)(A), substituted ''inserted during or subsequent to'' for ''implanted during''.

Subsec. (b)(12)(C). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(25), see 1987 Amendment note below.

Subsec. (b)(13), (14). Pub. L. 100–360, §411(f)(7)(A), redesignated par. (14) as (13).

Subsec. (c)(1)(A). Pub. L. 100–360, §202(e)(3)(A), designated existing provisions as cl. (i), inserted '', except as provided in clause (ii),'' after ''under this part, and'' and added cl. (ii) relating to payment for implementation and operation of the electronic system for covered outpatient drugs.

Subsec. (c)(1)(A)(ii). Pub. L. 100–485, §608(d)(5)(D), inserted '', including claims processing functions'' after ''and related functions''.

Subsec. (c)(2)(A), (3)(A). Pub. L. 100–360, §202(e)(5)(A), as amended by Pub. L. 100–485, §608(d)(5)(H), substituted ''Except as provided in paragraph (4), each'' for ''Each''.

Subsec. (c)(4). Pub. L. 100–360, §202(e)(5)(B), added par. (4) requiring contracts for the disbursement of funds with respect to claims for payment for covered outpatient drugs to provide for a payment cycle, and requiring interest if such requirements are not met.

Subsec. (f)(3). Pub. L. 100–485, §608(d)(5)(B), inserted '', including claims processing functions'' after ''and related functions''.

Pub. L. 100–360, §202(e)(1), added par. (3) which read as follows: ''with respect to implementation and operation (and related functions) of the electronic system established under subsection (*o*)(4) of this section, a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities.''

Subsec. (h)(1). Pub. L. 100–360, §202(c)(1)(A), inserted '', except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (*o*)(1) of this section)'' after ''part during such year''.

Subsec. (h)(2). Pub. L. 100–360, §202(e)(4)(A), inserted ''(other than a carrier described in subsection (f)(3) of this section)'' after ''Each carrier''.

Subsec. (h)(3)(B). Pub. L. 100–360, §411(i)(1)(A), substituted ''payment determination'' for ''claims determination'', ''shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order'' for ''including such information as the Secretary determines is generally provided'', ''enter into agreements'' for ''enter into arrangements'', and ''under this subparagraph by a carrier'' for ''under this subparagraph'' and inserted '', and such user fees shall be collected and retained by the carrier''.

Subsec. (h)(4). Pub. L. 100–360, §202(c)(1)(B), inserted at end ''In publishing directories under this paragraph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies.''

Subsec. (h)(5). Pub. L. 100–360, §223(b), designated existing provisions as subpar. (A), inserted ''through an annual mailing'', struck out at end ''The Secretary shall include such notice in the mailing of appropriate benefit checks provided under subchapter II of this chapter.'', and added subpar. (B).

Subsec. (h)(7). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(A), see 1987 Amendment note below.

Pub. L. 100–360, §223(c), in subpar. (A) inserted ''prominent'' before ''reminder'' and substituted ''and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),'' for ''7E), and'' and added subpar. (C).

Subsec. (h)(8). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(B), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(B), see 1987 Amendment note below.

Subsec. (i)(2), (3). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(C), see 1987 Amendment note below.

Subsec. (i)(3). Pub. L. 100–485, §608(d)(21)(A), substituted ''subsection (b)(3)'' for ''paragraph (3)''.

Subsec. (i)(4). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(E), see 1987 Amendment note below.

Subsec. (j)(1)(C)(i). Pub. L. 100–360, §411(f)(2)(F)(ii), added Pub. L. 100–203, §4042(c)(2), see 1987 Amendment note below.

Subsec. (j)(1)(C)(viii). Pub. L. 100–360, §411(f)(1)(A), amended Pub. L. 100–203, §4041(a)(1)(B), see 1987 Amendment note below.

Subsec. (j)(1)(C)(ix). Pub. L. 100–360, §411(f)(7)(B), added Pub. L. 100–203, §4048(e), see 1987 Amendment note below.

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 100–360, §411(f)(5)(B), struck out ''is'' after ''limit''.

Subsec. (j)(1)(D)(ii)(V). Pub. L. 100–360, §411(g)(2)(B), redesignated subcl. (IV) as (V) and struck out ''is'' after ''limit''.

Subsec. (j)(1)(D)(iii). Pub. L. 100–360, §411(g)(2)(C), amended Pub. L. 100–203, §4063(a)(2)(B), see 1987 Amendment note below.

Subsec. (j)(1)(D)(iv). Pub. L. 100–360, §411(f)(4)(C), substituted ''bills'' for ''imposes a charge''.

Subsec. (j)(2). Pub. L. 100–360, §411(i)(4)(C)(vi), as amended by Pub. L. 100–485, §608(d)(24)(B), added Pub. L. 100–203, §4085(i)(26), see 1987 Amendment note below.

Subsec. (*l*)(1)(C)(i). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(27), see 1987 Amendment note below.

Subsec. (n)(1). Pub. L. 100–360, § 411(f)(9)(A), in introductory provisions, struck out ''to a patient'' after ''includes a charge'', inserted ''the bill or request for'' after ''for which'', and substituted ''shares a practice'' for ''shares his practice'' and ''supervised the performance of the test, the'' for ''supervised the test, the''.

Subsec. (n)(1)(A). Pub. L. 100–485, § 608(d)(17), substituted ''the supplier's'' for ''the the supplier's''.

Pub. L. 100–360, § 411(f)(9)(B), as amended by Pub. L. 100–485, § 608(d)(21)(D), substituted ''(or other applicable limit)'' for ''to individuals enrolled under this part''.

Pub. L. 100–360, § 411(a)(3)(A), (C)(i), clarified that illegible matter after ''or, if lower, the'' was ''the supplier's reasonable charge to individuals enrolled under this part for the test''.

Subsec. (n)(2)(A). Pub. L. 100–360, § 411(f)(9)(C), inserted ''the payment amount specified in paragraph (1)(A) and'' after ''other than''.

Subsec. (n)(3). Pub. L. 100–360, § 411(f)(9)(D), struck out ''or supplier'' after ''such physician''.

Subsec. (*o*). Pub. L. 100–360, § 202(c)(1)(C), added subsec. (*o*) relating to ''participating pharmacies'' as entities authorized under State law to dispense covered outpatient drugs which had entered into agreements with Secretary to participate in catastrophic coverage program.

Subsec. (*o*)(1)(A)(i). Pub. L. 100–485, § 608(d)(5)(A)(i), substituted ''paragraph (4)'' for ''subparagraph (D)(i)''.

Subsec. (*o*)(1)(B)(ii). Pub. L. 100–485, § 608(d)(5)(A)(ii), substituted ''an eligible organization'' for ''eligible organization''.

Subsec. (p). Pub. L. 100–360, § 202(g), added subsec. (p).

1987—Subsec. (b)(2). Pub. L. 100–203, § 4082(c), as amended by Pub. L. 100–360, § 411(i)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 100–203, § 4041(a)(3)(A)(i), inserted at end ''In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H) and subsection (h) of this section.''

Subsec. (b)(3). Pub. L. 100–203, § 4085(i)(24), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''In the case of physicians' services'' for ''In the case of physician services'' and ''(with respect to physicians' services'' for ''(with respect to physicians services'' in fourth sentence.

Pub. L. 100–203, § 4045(c)(2)(D), as added by Pub. L. 100–360, § 411(f)(4)(B)(ii), inserted ''(or under any other provision of law affecting the prevailing charge level)'' in fourth sentence.

Pub. L. 100–203, § 4053(a), formerly § 4052(a), as renumbered and amended by Pub. L. 100–360, § 411(f)(11)(A), (14), inserted '', and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level'' before period at end of penultimate sentence.

Subsec. (b)(3)(B)(ii). Pub. L. 100–203, § 4096(a)(1)(A), as amended by Pub. L. 100–360, § 411(j)(4)(A), added subcl. (II), redesignated former subcl. (II) as (III), and inserted ''(and to refund amounts already collected)''.

Subsec. (b)(3)(C). Pub. L. 100–203, § 4085(i)(5), substituted ''less than $500'' for ''not more than $500''.

Subsec. (b)(4)(A)(iv). Pub. L. 100–203, § 4042(c)(1), formerly § 4042(c), as redesignated and amended by Pub. L. 100–360, § 411(f)(2)(F)(i), and by Pub. L. 100–485, § 608(d)(21)(B), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: ''In determining the prevailing charge level under the third and fourth sentences of paragraph (3) for a physicians' service furnished on or after January 1, 1987, by a nonparticipating physician, the Secretary shall set the level at 96 percent of the prevailing charge levels established under such sentences with respect to such service furnished by participating physicians.''

Subsec. (b)(4)(A)(v). Pub. L. 100–203, § 4041(a)(1)(A)(i), added cl. (v). Former cl. (v) redesignated (vi).

Subsec. (b)(4)(A)(vi). Pub. L. 100–203, § 4044(a), as amended by Pub. L. 100–360, § 411(f)(3)(A), added cl. (vi). Former cl. (vi) redesignated (vii).

Pub. L. 100–203, § 4041(a)(1)(A)(i), redesignated former cl. (v) as (vi).

Subsec. (b)(4)(A)(vii). Pub. L. 100–203, § 4042(b)(2)(A), as added by Pub. L. 100–360, § 411(f)(2)(D), substituted ''subsection (i)(3)'' for ''subparagraph (E)(ii)''.

Pub. L. 100–203, § 4044(a), as amended by Pub. L. 100–360, § 411(f)(3)(A), redesignated former cl. (vi) as (vii).

Subsec. (b)(4)(B)(iii). Pub. L. 100–203, § 4041(a)(1)(A)(ii), added cl. (iii).

Subsec. (b)(4)(E). Pub. L. 100–203, § 4042(b)(1)(D), as added by Pub. L. 100–360, § 411(f)(2)(C), redesignated subpar. (F) as (E). Former subpar. (E) transferred to subsec. (i).

Pub. L. 100–203, § 4042(b)(1)(C), as added by Pub. L. 100–360, § 411(f)(2)(C), struck out ''(E) In this section:'' before cl. (i), redesignated cls. (i) and (ii) as pars. (2) and (3), respectively, and transferred those pars. to subsec. (i).

Subsec. (b)(4)(F). Pub. L. 100–203, § 4042(b)(1)(D), as added by Pub. L. 100–360, § 411(f)(2)(C), redesignated subpar. (G) as (F). Former subpar. (F) redesignated (E).

Pub. L. 100–203, § 4042(a), added subpar. (F).

Subsec. (b)(4)(G). Pub. L. 100–203, § 4042(b)(1)(D), as added by Pub. L. 100–360, § 411(f)(2)(C), redesignated subpar. (G) as (F).

Pub. L. 100–203, § 4047(a), added subpar. (G).

Subsec. (b)(7)(B)(iii). Pub. L. 100–203, § 4085(i)(22)(C), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''an assignment-related basis'' for ''the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title''.

Subsec. (b)(10). Pub. L. 100–203, § 4045(a), amended par. (10) generally, revising and restating as subpars. (A) to (D) provisions of former subpars. (A) to (C).

Subsec. (b)(11)(B)(i). Pub. L. 100–203, § 4045(c)(2)(B), as amended by Pub. L. 100–360, § 411(f)(4)(B)(i), struck out ''and shall be further reduced by 2 percent with respect to procedures performed in 1988'' after ''in 1987'' and struck out second sentence which read as follows: ''A reduced prevailing charge under this subparagraph shall become the prevailing charge level for subsequent years for purposes of applying the economic index under the fourth sentence of paragraph (3).''

Subsec. (b)(11)(C). Pub. L. 100–203, § 4063(a)(1)(A), designated existing provisions as cl. (i) and added cl. (ii).

Pub. L. 100–203, § 4046(a)(1)(B), (C), added subpar. (C) and redesignated former subpar. (C) as (D).

Pub. L. 100–203, § 4045(c)(1)(A), struck out former cl. (i) designation before ''In the case of'' and substituted '', the physician's actual charge is subject to a limit under subsection (j)(1)(D).'' for ''(subject to clause (iv)), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.'', and struck out former cls. (ii) to (iv) which read as follows:

''(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in clause (i).

''(iii) If a physician knowingly and willfully imposes charges in violation of clause (i), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) of this section.

''(iv) This subparagraph shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title.''

Subsec. (b)(11)(D). Pub. L. 100–203, § 4063(a)(1)(B), which directed that subpar. (D) be amended by inserting ''or item'' after ''service'' or ''services'' each place either appears, was executed by inserting ''or item'' after ''service'' wherever appearing. The word ''services'' does not appear because of a prior amendment by

section 4045(c)(1)(A) of Pub. L. 100–203 to subpar. (D), formerly (C), see above.

Pub. L. 100–203, § 4046(a)(1)(A), (B), redesignated former subpar. (C) as (D) and substituted ''subparagraph (B) or (C)'' for ''subparagraph (B)''.

Subsec. (b)(12)(C). Pub. L. 100–203, § 4085(i)(25), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''money penalty'' for ''monetary penalty'' and amended second sentence generally. Prior to amendment, second sentence read as follows: ''Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section.''

Subsec. (b)(14). Pub. L. 100–203, § 4048(a), added par. (14).

Subsec. (c)(1). Pub. L. 100–203, § 4041(a)(3)(A)(ii), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 100–203, § 4035(a)(2), inserted at end ''The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.''

Subsec. (c)(3). Pub. L. 100–203, § 4031(a)(2), added par. (3).

Subsec. (h)(3). Pub. L. 100–203, § 4081(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (h)(5). Pub. L. 100–203, § 4085(i)(6), substituted ''the participation program'' for ''the the participation program''.

Subsec. (h)(7). Pub. L. 100–203, § 4042(b)(1)(A), as added by Pub. L. 100–360, § 411(f)(2)(C), struck out '', described in paragraph (8)'' after ''assignment-related basis'' in introductory provisions.

Subsec. (h)(8). Pub. L. 100–203, § 4042(b)(1)(B), as added by Pub. L. 100–360, § 411(f)(2)(C), substituted ''(1) A'' for ''(8) For purposes of this subchapter, a'', indented such par. 2 ems, and inserted subsec. (i) designation and ''For purposes of this subchapter:'', effectively transferring former subsec. (h)(8) to subsec. (i).

Subsec. (i). Pub. L. 100–203, § 4042(b)(1)(B), as added by Pub. L. 100–360, § 411(f)(2)(C), transferred introductory provisions and par. (1) from former subsec. (h)(8).

Subsec. (i)(2), (3). Pub. L. 100–203, § 4042(b)(1)(C), as added by Pub. L. 100–360, § 411(f)(2)(C), transferred pars. (2) and (3) from subsec. (b)(4)(E).

Subsec. (i)(4). Pub. L. 100–203, § 4042(b)(1)(E), as added by Pub. L. 100–360, § 411(f)(2)(C), added par. (4).

Subsec. (j)(1)(B)(i). Pub. L. 100–203, § 4054(a)(1), (2), formerly § 4053(a)(1), (2), as renumbered by Pub. L. 100–360, § 411(f)(14), substituted ''the actual charges of each such physician'' for ''each such physician's actual charges'' and ''on a repeated basis for such a service an actual charge'' for ''for such a service a physician's actual charge (as defined in subparagraph (C)(vi)''.

Subsec. (j)(1)(C)(i). Pub. L. 100–203, § 4085(i)(7)(A), inserted ''maximum allowable'' after ''If the physician's''.

Pub. L. 100–203, § 4042(c)(2), as added by Pub. L. 100–360, § 411(f)(2)(F)(ii), substituted ''applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved'' for ''prevailing charge for the year involved for such service furnished by nonparticipating physicians'' in subcls. (I) and (II).

Subsec. (j)(1)(C)(v). Pub. L. 100–203, § 4085(i)(7)(B), substituted ''1986'' for ''1987''.

Subsec. (j)(1)(C)(vi). Pub. L. 100–203, § 4054(a)(3), formerly § 4053(a)(3), as renumbered by Pub. L. 100–360, § 411(f)(14), struck out ''and subparagraph (B)'' after ''purposes of this subparagraph''.

Subsec. (j)(1)(C)(vii). Pub. L. 100–203, § 4085(i)(7)(C), added cl. (vii).

Subsec. (j)(1)(C)(viii). Pub. L. 100–203, § 4041(a)(1)(B), as amended by Pub. L. 100–360, § 411(f)(1)(A), added cl. (viii).

Subsec. (j)(1)(C)(ix). Pub. L. 100–203, § 4048(e), as added by Pub. L. 100–360, § 411(f)(7)(B), added cl. (ix).

Subsec. (j)(1)(D). Pub. L. 100–203, § 4045(c)(1)(B), added subpar. (D).

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 100–203, § 4063(a)(2)(A), added subcl. (IV) relating to establishment of reasonable charge limit under subsec. (b)(11)(C)(ii) of this section.

Pub. L. 100–203, § 4046(a)(2)(A), added subcl. (IV) relating to establishment of prevailing charge limit under subsec. (b)(11)(C)(i) of this section. Former subcl. (IV) redesignated (V).

Subsec. (j)(1)(D)(ii)(V), (VI). Pub. L. 100–203, § 4063(a)(2)(A), redesignated former subcl. (V) as (VI).

Pub. L. 100–203, § 4046(a)(2)(A), redesignated former subcl. (IV) as (V).

Subsec. (j)(1)(D)(iii). Pub. L. 100–203, § 4063(a)(2)(B), as amended by Pub. L. 100–360, § 411(g)(2)(C), struck out ''or'' at end of subcl. (I), substituted ''; or'' for period at end of subcl. (II), and added subcl. (III).

Pub. L. 100–203, § 4046(a)(2)(B), substituted '', (b)(11)(B), or (b)(11)(C)(i)'' for ''or (b)(11)(B)'' in subcl. (II).

Subsec. (j)(2). Pub. L. 100–203, § 4085(i)(26), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), and amended by Pub. L. 100–485, § 608(d)(24)(B), substituted ''chapter'' for ''subchapter'' in subpar. (A), struck out ''the imposition of'' before ''civil monetary penalties'' and inserted ''and assessments'' in subpar. (B), substituted ''chapter'' for ''subchapter'' in two places in last sentence, and amended last sentence generally. Prior to amendment, last sentence read as follows: ''No payment may be made under this chapter with respect to any item or service furnished by a physician during the period when he is excluded from participation in the programs under this chapter pursuant to this subsection.''

Pub. L. 100–93, § 8(c)(2)(A), amended subpar. (A) generally and substituted ''excluded from participation in the programs'' for ''barred from participation in the program'' in last sentence. Prior to amendment, subpar. (A) read as follows: ''barring a physician from participation under the program under this subchapter for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1395y(d) of this title, or''.

Subsec. (j)(3)(A). Pub. L. 100–93, § 8(c)(2)(B), substituted ''exclude'' for ''bar''.

Subsec. (k)(1), (2). Pub. L. 100–203, § 4085(g)(1), substituted ''subsection (j)(2) in the case of surgery performed on or after March 1, 1987'' for ''subsection (j)(2)''.

Subsec. (*l*)(1)(A)(iii). Pub. L. 100–203, § 4096(a)(1)(B), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (*l*)(1)(C). Pub. L. 100–203, § 4096(a)(1)(C), inserted ''in the case described in subparagraph (A)(iii)(I)'' after ''to an individual'' in introductory provisions.

Subsec. (*l*)(1)(C)(i). Pub. L. 100–203, § 4085(i)(27), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), inserted ''the physician establishes that'' after ''(i)''.

Subsec. (n). Pub. L. 100–203, § 4051(a), added subsec. (n).

1986—Subsec. (b)(3). Pub. L. 99–509, § 9331(c)(3)(A), inserted ''or (with respect to physicians services furnished in a year after 1987) the level determined under this sentence for the previous year'' after ''ending June 30, 1973,'' and ''year-to-year'' before ''economic changes'' in fourth sentence.

Pub. L. 99–272, § 9301(d)(1)(B), (C), substituted ''June 30 last preceding the start of the calendar year'' for ''March 31 last preceding the start of the twelve-month period (beginning October 1 of each year)'' in third sentence, and struck out ''the twelve-month period beginning on October 1 in'' before ''any calendar year after 1974'' in eighth sentence.

Subsec. (b)(3)(C). Pub. L. 99–509, § 9341(a)(2), substituted ''at least $100, but not more than $500'' for ''$100 or more''.

Subsec. (b)(3)(F). Pub. L. 99–272, § 9301(d)(1)(A), struck out ''(ending on September 30)'' after ''before the year''.

Subsec. (b)(3)(G). Pub. L. 99–509, § 9331(b)(2), added subpar. (G).

Subsec. (b)(3)(H). Pub. L. 99–509, § 9332(a)(1), added subpar. (H).

Subsec. (b)(4)(A)(i), (ii). Pub. L. 99–272, § 9301(b)(1)(A), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4)(A)(iii). Pub. L. 99–509, § 9331(a)(1), added cl. (iii) and struck out former cl. (iii) which read as follows: ''In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1) of this section) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous calendar year (without regard to clause (ii)(II)) for physicians who were participating physicians during that year.''

Pub. L. 99–272, § 9301(b)(1)(A)(ii), added cl. (iii).

Subsec. (b)(4)(A)(iv), (v). Pub. L. 99–509, § 9331(a)(1), added cls. (iv) and (v).

Subsec. (b)(4)(B). Pub. L. 99–272, § 9301(b)(1)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4)(C). Pub. L. 99–509, § 9331(a)(2), directed amendment of subpar. (C) by striking out ''(i)'' after ''(C)'' and striking out cl. (ii), applicable to services furnished on or after Jan. 1, 1987, which is identical to amendment by Pub. L. 99–514, § 1895(b)(14)(A), as amended, effective as if included in enactment of Pub. L. 99–272.

Pub. L. 99–514, § 1895(b)(14)(A), as amended by Pub. L. 99–509, § 9307(c)(2)(A), struck out cl. (i) designation, and struck out cl. (ii) which read as follows: ''In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the periods beginning after December 31, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).''

Pub. L. 99–272, § 9301(b)(1)(C), designated existing provisions as cl. (i), substituted ''subparagraph (A)(i)'' for ''subparagraph (A)'' wherever appearing, and added cl. (ii).

Subsec. (b)(4)(D)(i) to (iii). Pub. L. 99–272, § 9301(b)(1)(D), designated existing provisions as cl. (i), substituted ''In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985'' for ''In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1985, or October 1, 1986, by a physician who at no time for any services furnished during the 12-month period beginning October 1, 1984, was a participating physician (as defined in subsection (h)(1))'', and added cls. (ii) and (iii).

Subsec. (b)(4)(D)(iv). Pub. L. 99–509, § 9331(b)(3), added cl. (iv).

Subsec. (b)(4)(E). Pub. L. 99–509, § 9331(a)(3), added subpar. (E).

Subsec. (b)(6). Pub. L. 99–509, § 9338(c), substituted ''except that (A) payment may be made (i)'' for ''except that payment may be made (A)(i)'', substituted ''(B) payment may be made'' for ''or (B)'', and inserted before the period at end '', and (C) in the case of services described in section 1395x(s)(2)(K) of this title payment shall be made to the employer of the physician assistant involved''.

Subsec. (b)(7)(B)(ii)(III). Pub. L. 99–272, § 9219(b)(1)(A), realigned margin of subcl. (III).

Subsec. (b)(7)(B)(iii). Pub. L. 99–272, § 9219(b)(2)(A), realigned margin of cl. (iii).

Subsec. (b)(8). Pub. L. 99–509, § 9333(a), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpars. (B) and (C).

Pub. L. 99–272, § 9304(a), added par. (8).

Subsec. (b)(9). Pub. L. 99–509, § 9333(b), added par. (9). Former par. (9) redesignated (11).

Pub. L. 99–272, § 9306(a), added par. (9).

Subsec. (b)(10). Pub. L. 99–509, § 9333(b), added par. (10).

Subsec. (b)(11). Pub. L. 99–509, § 9334(a), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpars. (B) and (C).

Pub. L. 99–509, § 9333(b), redesignated former par. (9) as (11).

Subsec. (b)(12). Pub. L. 99–509, § 9338(b), added par. (12).

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

Subsec. (h)(1). Pub. L. 99–272, § 9301(d)(2), substituted ''before the beginning of any year beginning with 1984'' for ''before October 1 of any year beginning with 1984'', ''on an assignment-related basis'' for ''on the basis of an assignment described in subsection (b)(3)(B)(ii) of this section, in accordance with subsection (b)(6)(B) of this section, or under the procedure described in section 1395gg(f)(1) of this title'', ''during such year'' for ''during the 12-month period beginning on October 1 of such year'', ''after the beginning of a year'' for ''after October 1 of a year'', and ''during the remainder of the year'' for ''during the remainder of the 12-month period beginning on such October 1''.

Subsec. (h)(2). Pub. L. 99–509, § 9332(b)(1)(A), struck out period at end and substituted ''and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.''

Subsec. (h)(4). Pub. L. 99–509, § 9332(b)(2), inserted at end ''Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.''

Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (2) of subsec. (i) as par. (4) of this subsection.

Subsec. (h)(5). Pub. L. 99–509, § 9332(b)(1)(B), substituted ''the participation program under this subsection and the publication and availability of the directories'' for ''publication of the directories'' and inserted at end ''The Secretary shall include such notice in the mailing of appropriate benefit checks provided under subchapter II of this chapter.''

Pub. L. 99–514, § 1895(b)(15)(A), struck out ''such'' before ''the directories'' and before ''the appropriate area directory''.

Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (3) of subsec. (i) as par. (5) of this subsection.

Subsec. (h)(6). Pub. L. 99–509, § 9332(b)(1)(C), inserted before period at end of second sentence ''and that an appropriate number of copies of each such directory is sent to hospitals located in the area'' and inserted at end ''Such copies shall be sent free of charge.''

Pub. L. 99–514, § 1895(b)(15)(B), substituted ''the'' for ''the the'' before ''directories''.

Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (4) of subsec. (i) as par. (6) of this subsection.

Subsec. (h)(7), (8). Pub. L. 99–272, § 9301(c)(4), added pars. (7) and (8).

Subsec. (i)(1). Pub. L. 99–272, § 9301(c)(3)(A), struck out par. (1) which required the Secretary to publish a list containing the name, address, specialty, and percent of claims submitted with respect to each physician and supplier during preceding year that were paid on the basis of an assignment described in subsec. (b)(3)(B)(ii) of this section, in accordance with subsec. (b)(6)(B) of this section, or under procedure described in section 1395gg(f)(1) of this title.

Subsec. (i)(2). Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (2) of this subsection as par. (4) of subsec. (h).

Pub. L. 99–272, § 9301(d)(3), substituted ''year'' for ''fiscal year'', wherever appearing.

Pub. L. 99–272, § 9301(c)(2)(A), (B), (3)(B), substituted ''shall publish directories (for appropriate local geo-

graphic areas)'' for ''shall publish a directory'', inserted ''for that area'' before ''for that fiscal year'', substituted ''Each directory shall'' for ''The directory shall'', and substituted ''paragraph (1)'' for ''subsection (h)(1) of this section''.

Subsec. (i)(3). Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (3) of this subsection as par. (5) of subsec. (h).

Pub. L. 99–272, § 9301(c)(2)(C), (3)(C), struck out ''directory'' first place it appeared and inserted in lieu ''the directories'', struck out ''directory'' second place it appeared and inserted in lieu ''the appropriate area directory or directories'', and struck out ''list and'' wherever appearing.

Subsec. (i)(4). Pub. L. 99–272, § 9301(c)(3)(D), redesignated par. (4) of this subsection as par. (6) of subsec. (h).

Pub. L. 99–272, § 9301(c)(2)(D), (3)(C), struck out ''list and'' after ''The Secretary shall provide that the'' in first sentence, substituted ''the directories shall'' for ''directory shall'', and inserted provision requiring the Secretary to provide that each appropriate area directory be sent to each participating physician located in that area.

Subsec. (j)(1). Pub. L. 99–509, § 9331(b)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Pub. L. 99–272, § 9301(b)(2), amended first sentence generally. Prior to amendment, first sentence read as follows: ''In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services furnished during the 15-month period beginning July 1, 1984.''

Subsec. (j)(2). Pub. L. 99–509, § 9320(e)(3), substituted ''this paragraph'' for ''paragraph (1) or subsection (k) of this section'' in introductory text.

Pub. L. 99–272, § 9307(c)(1), inserted reference to subsec. (k) of this section in introductory text.

Subsec. (k). Pub. L. 99–514, § 1895(b)(16)(A), inserted ''presents or causes to be presented a claim or'' in pars. (1) and (2).

Pub. L. 99–272, § 9307(c)(2), added subsec. (k).

Subsec. (*l*). Pub. L. 99–509, § 9332(c)(1), added subsec. (*l*).

Subsec. (m). Pub. L. 99–509, § 9332(d)(1), added subsec. (m).

1984—Subsec. (b)(2). Pub. L. 98–369, § 2326(c)(2), inserted at end provision that the Secretary publish in the Federal Register standards and criteria for efficient and effective performance of contract obligations under this section and provide an opportunity for public comment prior to implementation.

Subsec. (b)(3). Pub. L. 98–369, § 2306(b)(1)(B), (C), substituted ''during the 12-month period ending on the March 31 last preceding'' for ''during the last preceding calendar year elapsing prior to'' in third sentence and substituted ''October 1'' for ''July 1'' wherever appearing in third and eighth sentences.

Pub. L. 98–369, § 2354(b)(14), substituted ''(I)'' and ''(II)'' for ''(i)'' and ''(ii)'', respectively in concluding provisions.

Pub. L. 98–369, § 2663(j)(2)(F)(iv), substituted ''Health and Human Services'' for ''Health, Education, and Welfare'' in concluding provisions.

Subsec. (b)(3)(B)(ii)(II). Pub. L. 98–369, § 2354(b)(13), struck out the period after ''subchapter''.

Subsec. (b)(3)(F). Pub. L. 98–369, § 2306(b)(1)(A), substituted ''September 30'' for ''June 30''.

Subsec. (b)(4), (5). Pub. L. 98–369, § 2306(a), added par. (4) and redesignated former pars. (4) and (5) as (5) and (6), respectively.

Subsec. (b)(6). Pub. L. 98–369, § 2339, redesignated cl. (A) as cl. (A)(i) and former cl. (B) as cl. (A)(ii), added a new cl. (B), and in the provisions after cl. (B), substituted ''clause (A) of such sentence'' for ''clause (A) or (B) of such sentence''.

Pub. L. 98–369, § 2306(a), redesignated par. (5) as (6). Former par. (6) redesignated (7).

Subsec. (b)(7). Pub. L. 98–369, § 2306(a), redesignated par. (6) as (7).

Subsec. (b)(7)(A). Pub. L. 98–617, § 3(b)(5)(B), struck out at end ''If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title, notwithstanding clause (ii) of this subparagraph, the carrier shall provide for payment in an amount equal to 90 percent of the prevailing charges paid for similar services in the same locality.''

Pub. L. 98–369, § 2307(a)(1), as amended by Pub. L. 98–617, § 3(a)(1), inserted ''If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title, notwithstanding clause (ii) of this subparagraph, the carrier shall provide for payment in an amount equal to 90 percent of the prevailing charges paid for similar services in the same locality.'' at the end.

Subsec. (b)(7)(A)(ii). Pub. L. 98–617, § 3(b)(5)(A), substituted ''the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B)'' for ''the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B))''.

Subsec. (b)(7)(B)(i). Pub. L. 98–369, § 2307(a)(2)(A), (B), substituted ''physician who is not a teaching physician (as defined by the Secretary)'' for ''physician who has a substantial practice outside the teaching setting'' and ''practice outside the teaching setting'' for ''outside practice''.

Subsec. (b)(7)(B)(ii). Pub. L. 98–369, § 2307(a)(2)(C), (D), substituted ''In the case of a teaching physician'' for ''In the case of a physician who does not have a practice described in clause (i)'' and ''greatest'' for ''greater''.

Subsec. (b)(7)(B)(ii)(III). Pub. L. 98–369, § 2307(a)(2)(E)–(G), added subcl. (III).

Subsec. (b)(7)(B)(iii). Pub. L. 98–617, § 3(b)(6), added cl. (iii).

Subsec. (c). Pub. L. 98–369, § 2326(d)(2), inserted provision that the Secretary, in determining a carrier's necessary and proper cost of administration with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract.

Subsec. (h). Pub. L. 98–369, § 2306(c), added subsec. (h).

Pub. L. 98–369, § 2303(e), struck out subsec. (h) providing for payment for laboratory tests.

Subsecs. (i), (j). Pub. L. 98–369, § 2306(c), added subsecs. (i) and (j).

1982—Subsec. (b)(3)(B)(ii)(II). Pub. L. 97–248, § 128(d)(1), substituted ''section 1395y(a)'' for ''section 1395y''.

Subsec. (b)(3). Pub. L. 97–248, § 104(a), in provisions following subpar. (F), inserted provisions that in determining the reasonable charge for outpatient services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility.

Subsec. (b)(6)(D). Pub. L. 97–248, § 113(a), added subpar. (D).

1981—Subsec. (b)(3). Pub. L. 97–35 inserted provision that the amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1395x(v)(1)(K) of this title.

1980—Subsec. (b)(3). Pub. L. 96–499, § 946(a), in provisions following subpar. (F), substituted ''service is rendered'' for ''bill is submitted or the request for payment is made''.

Subsec. (b)(3)(F). Pub. L. 96–499, § 946(b), added subpar. (F).

Subsec. (b)(6). Pub. L. 96–499, § 948(b), added par. (6).

Subsec. (h). Pub. L. 96–499, § 918(a)(1), added subsec. (h).

1977—Subsec. (b)(3). Pub. L. 95–216 provided that, with respect to power-operated wheelchairs for which payment may be made in accordance with section 1395x(s)(6) of this title, charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

Subsec. (b)(5). Pub. L. 95–142 inserted provisions relating to payments under a reassignment or power of attorney in cases other than direct payments to physicians or service providers.

1976—Subsec. (b)(3). Pub. L. 94–368 substituted ''for the twelve-month period beginning on July 1 in any calendar year after 1974'' for ''for the fiscal year beginning July 1, 1975,'', ''prior to the start of the twelve-month period (beginning July 1, of each year) in which the bill is submitted or the request for payment is made'' for ''prior to the start of the fiscal year in which the bill is submitted or the request for payment is made'', and ''for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence'' for ''for any fiscal year beginning after June 30, 1973,''.

1975—Subsec. (b)(3). Pub. L. 94–182 inserted provisions relating to raising for fiscal year beginning July 1, 1975 inadequate prevailing charge levels for services of physicians in certain localities.

1974—Subsec. (g). Pub. L. 93–445 substituted ''section 231f(d) of title 45'' for ''section 228s–2(b) of title 45''.

1972—Subsec. (a). Pub. L. 92–603, § 227(e)(3), substituted ''which involve payments for physicians' services on a reasonable charge basis'' for ''which involve payments for physicians' services''.

Subsec. (b)(3). Pub. L. 92–603, §§ 244(a), 258(a), inserted provisions relating to determination of reasonableness of physician charges, medical services, supplies, and equipment and for the extension of time for filing claims for supplementary medical insurance benefits where the delay is due to administrative error, at end thereof.

Subsec. (b)(3)(B)(ii). Pub. L. 92–603, §§ 211(c)(3), 281(d), designated existing provisions as subcl. (I), added subcl. II, inserted exception in the case of services furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title.

Subsec. (b)(3)(C). Pub. L. 92–603, § 262(a), inserted provisions setting a $100 minimum amount on claims to establish entitlement to a hearing.

Subsec. (b)(5). Pub. L. 92–603, § 236(a), added par. (5).

Subsec. (g). Pub. L. 92–603, § 263(d)(5), added subsec. (g).

1968—Subsec. (b)(3)(B). Pub. L. 90–248 provided that payment be made on the basis of an itemized bill instead of a receipted bill as formerly required, and established a time limit within which payment may be requested, and inserted ''(except as otherwise provided in section 1395gg(f) of this title)'' after ''payment will''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104–14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 5012(c)(2) of Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2019, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395*l* of this title.

Pub. L. 114–255, div. C, title XVI, § 16006(b), Dec. 13, 2016, 130 Stat. 1328, provided that:

''(1) EFFECTIVE DATE.—The amendments made by subsection (a) [amending this section] shall apply to services furnished beginning not later than six months after the date of the enactment of this Act [Dec. 13, 2016].

''(2) IMPLEMENTATION.—The Secretary of Health and Human Services may implement subparagraph (J) of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)), as added by subsection (a)(2), by program instruction or otherwise.''

EFFECTIVE DATE OF 2011 AMENDMENT

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

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6404(a)(2)(A) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2010, and in case of services furnished before Jan. 1, 2010, a bill or request for payment under 42 U.S.C. 1395u(b)(3)(B) to be filed not later than Dec. 31, 2010, see section 6404(b) of Pub. L. 111–148, set out as a note under section 1395f of this title.

Amendment by section 6406(a) of Pub. L. 111–148 applicable to orders, certifications, and referrals made on or after Jan. 1, 2010, see section 6406(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 154(a)(2)(B) of Pub. L. 110–275 effective June 30, 2008, see section 154(e) of Pub. L. 110–275, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–54, § 1(b), Aug. 3, 2007, 121 Stat. 551, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this section [Aug. 3, 2007].''

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, § 110(b), Dec. 20, 2006, 120 Stat. 2985, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs furnished on or after January 1, 2008. The Secretary of Health and Human Services shall address the implementation of such amendment in the rulemaking process under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for payment for physicians' services for 2008, consistent with the previous sentence.''

Pub. L. 109–432, div. B, title II, § 205(c), Dec. 20, 2006, 120 Stat. 2990, provided that: ''The amendments made by this section [amending this section, section 1395ww of this title, and provisions set out as a note under section 1395eee of this title] shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).''

Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title V, § 5114(c), Feb. 8, 2006, 120 Stat. 45, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to services furnished on or after January 1, 2006.''

Amendment by section 5202(a)(2) of Pub. L. 109–171 applicable to claims submitted on or after Jan. 1, 2006, see section 5202(b) of Pub. L. 109–171, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 627(b)(2) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2005, see section 627(c) of Pub. L. 108–173, set out as a note under section 1395*l* of this title.

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

Pub. L. 108–173, title IX, §952(c), Dec. 8, 2003, 117 Stat. 2427, provided that: ''The amendments made by this section [amending this section] shall apply to payments made on or after the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title I, §105(d)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §105(e)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title I, §114(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to items furnished on or after January 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title II, §222(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, §1(a)(6) [title III, §313(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499, provided that: ''The amendments made by subsections (a) and (b) [amending this section and sections 1395y and 1395cc of this title] shall apply to services furnished on or after January 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title IV, §432(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that: ''The amendments made by this section [amending this section and sections 1395y and 1395qq of this title] shall apply to services furnished on or after July 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §305(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, provided that: ''The amendments made by this section [amending this section and section 1395y of this title] shall apply to payments for services provided on or after the date of enactment of this Act [Nov. 29, 1999].''

Amendment by section 1000(a)(6) [title III, §321(k)(4)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

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

Amendment by section 4205(d)(3)(B) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4205(d)(4) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4302(c), Aug. 5, 1997, 111 Stat. 382, provided that: ''The amendments made by this section [amending this section and section 1395cc of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and apply to the entry and renewal of contracts on or after such date.''

Amendment by section 4315(a) of Pub. L. 105–33, to the extent such amendment substitutes fee schedules for reasonable charges, applicable to particular services as of date specified by the Secretary of Health and Human Services, see section 4315(c) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4316(a) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4316(c) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, §4317(c), Aug. 5, 1997, 111 Stat. 392, provided that: ''The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 1998.''

Amendment by section 4432(b)(2), (4) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4512(b)(2), (c) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4512(d) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4556(a) of Pub. L. 105–33 applicable to drugs and biologicals furnished on or after Jan. 1, 1998, see section 4556(d) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4603(c)(2)(B)(i) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

Amendment by section 4611(d) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 123(b)(1), (2)(B) of Pub. L. 103–432 applicable to services furnished on or after Jan. 1, 1995, see section 123(f)(2) of Pub. L. 103–432, set out as a note under section 1395*l* of this title.

Pub. L. 103–432, title I, §123(f)(3), (4), Oct. 31, 1994, 108 Stat. 4413, provided that:

''(3) EOMBS.—The amendments made by subsection (c)(1) [amending this section] shall apply to explanations of benefits provided on or after July 1, 1995.

''(4) CARRIER DETERMINATIONS.—The amendments made by subsection (c)(2) [amending this section] shall apply to contracts as of January 1, 1995.''

Pub. L. 103–432, title I, §125(b)(2), Oct. 31, 1994, 108 Stat. 4414, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act [Oct. 31, 1994].''

Amendment by section 126(a)(1), (c), (e), (g)(9) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 126(i) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Pub. L. 103–432, title I, §126(h)(2), Oct. 31, 1994, 108 Stat. 4416, provided that the amendment made by that section is effective for payments for fiscal years beginning with fiscal year 1994.

Pub. L. 103–432, title I, §135(b)(2), Oct. 31, 1994, 108 Stat. 4423, provided that the amendment made by that section is effective for standards applied for contract years beginning after Oct. 31, 1994.

Amendment by section 151(b)(1)(B), (2)(B) of Pub. L. 103–432 applicable to contracts with fiscal intermediaries and carriers under this subchapter for contract years beginning with 1995, see section 151(b)(4) of Pub. L. 103–432, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13515(d), Aug. 10, 1993, 107 Stat. 583, provided that: ''The amendments made by subsection (a) [amending this section and section

1395w–4 of this title] shall apply to services furnished on or after January 1, 1994.''

Amendment by section 13568(a), (b) of Pub. L. 103–66 applicable to claims received on or after Oct. 1, 1993, see section 13568(c) of Pub. L. 103–66, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4105(b)(3), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, § 126(g)(2)(A)(ii), Oct. 31, 1994, 108 Stat. 4415, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4106(d), Nov. 5, 1990, 104 Stat. 1388–62, provided that:

''(1) The amendments made by subsection (a) [amending this section and provisions set out below] apply to services furnished after 1990, except that—

''(A) the provisions concerning the third and fourth years of practice apply only to physicians' services furnished after 1990 and 1991, respectively, and

''(B) the provisions concerning the second, third, and fourth years of practice apply only to services of a health care practitioner furnished after 1991, 1992, and 1993, respectively.

''(2) The amendments made by subsection (b) [amending this section and section 1395w–4 of this title] shall apply to services furnished after 1991.''

Pub. L. 101–508, title IV, § 4108(b), Nov. 5, 1990, 104 Stat. 1388–63, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to tests and services furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4110(b), Nov. 5, 1990, 104 Stat. 1388–64, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, § 4118(a)(3), Nov. 5, 1990, 104 Stat. 1388–67, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] apply to services furnished after March 1990.''

Pub. L. 101–508, title IV, § 4118(f)(2)(A), Nov. 5, 1990, 104 Stat. 1388–69, provided that the amendment by that section is effective as if included in the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239.

Pub. L. 101–508, title IV, § 4118(f)(2)(B), Nov. 5, 1990, 104 Stat. 1388–69, provided that the amendment by that section is effective Jan. 1, 1991.

Amendment by section 4155(c) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6102(e)(3), Dec. 19, 1989, 103 Stat. 2187, provided that the amendment made by that section is effective for physicians' services furnished on or after Jan. 1, 1992.

Pub. L. 101–239, title VI, § 6106(b), Dec. 19, 1989, 103 Stat. 2210, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1990.''

Pub. L. 101–239, title VI, § 6108(a)(2), Dec. 19, 1989, 103 Stat. 2212, as amended by Pub. L. 101–508, title IV, § 4106(a)(2), Nov. 5, 1990, 104 Stat. 1388–61, provided that:

''(A) Subject to subparagraph (B), the amendments made by paragraph (1) [amending this section] apply to services furnished in 1990 or 1991 which were subject to the first sentence of section 1842(b)(4)(F) of the Social Security Act [42 U.S.C. 1395u(b)(4)(F)] in 1989 or 1990.

''(B) The amendments made by paragraph (1) shall not apply to services furnished in 1990 before April 1, 1990. With respect to physicians' services furnished during 1990 on and after April 1, such amendments shall be applied as though any reference, in the matter inserted by such amendments, to the 'first calendar year during which the preceding sentence no longer applies' were deemed a reference to the remainder of 1990.''

Pub. L. 101–239, title VI, § 6108(b)(3), Dec. 19, 1989, 103 Stat. 2213, provided that: ''The amendments made by this subsection [amending this section] apply to procedures performed after March 31, 1990.''

Pub. L. 101–239, title VI, § 6114(f), Dec. 19, 1989, 103 Stat. 2218, provided that: ''The amendments made by this section [amending this section and section 1395x of this title] shall apply to services furnished on or after April 1, 1990.''

Amendment by section 6202(d)(2) of Pub. L. 101–239 applicable to agreements and contracts entered into or renewed on or after Dec. 19, 1989, see section 6202(d)(3) of Pub. L. 101–239, set out as a note under section 1395h of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Pub. L. 101–234, title III, § 301(e), Dec. 13, 1989, 103 Stat. 1986, provided that: ''The provisions of this section [amending this section and sections 1395m, 1395cc, 1395*ll*, and 1395ww of this title, enacting provisions set out as notes under section 1395m of this title, and repealing provisions set out as notes under sections 1395b, 1395b–1, 1395b–2, and 1395h of this title and section 8902 of Title 5, Government Organization and Employees] (other than subsections (c) and (d) [amending this section and sections 1395m, 1395cc, 1395*ll*, and 1395ww of this title and enacting provisions set out as a note under section 1395m of this title]) shall take effect January 1, 1990, except that—

''(1) the repeal of section 421 of MCCA [Pub. L. 100–360, set out as a note under section 1395b of this title] shall not apply to duplicative part A benefits for periods before January 1, 1990, and

''(2) the amendments made by subsection (b) [amending this section and sections 1395m, 1395cc, 1395*ll*, and 1395ww of this title] shall take effect on the date of the enactment of this Act [Dec. 13, 1989].''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title II, § 202(m), July 1, 1988, 102 Stat. 721, as amended by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981, provided that:

''(1) [Repealed. Prior to repeal by Pub. L. 101–234, par. (1) read as follows: 'IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section [enacting section 1395w–3 of this title and amending this section and sections 1320a–7a, 1395*l*, 1395m, 1395x, 1395y, 1395cc, 1395mm, and 1396b of this title] shall apply to items dispensed on or after January 1, 1990.']

''(2) [Repealed. Prior to repeal by Pub. L. 101–234, par. (2) read as follows: 'CARRIERS.—The amendments made by subsection (e) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]; except that the amendments made by subsection (e)(5) [amending this section] shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.']

''(3) [Repealed. Prior to repeal by Pub. L. 101–234, par. (3) read as follows: 'HMO/CMP ENROLLMENTS.—The amendment made by subsection (f) [amending section 1395mm of this title] shall apply to enrollments effected on or after January 1, 1990.']

''(4) DIAGNOSTIC CODING.—The amendment made by subsection (g) [amending this section] shall apply to services furnished after March 31, 1989.

''(5) [Repealed. Prior to repeal by Pub. L. 101–234, par. (5) read as follows: 'TRANSITION.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall

be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.'].''

[Amendment of section 202(m) of Pub. L. 100–360, set out above, effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 1320a–7a of this title.]

Pub. L. 100–360, title II, §223(d)(2), (3), July 1, 1988, 102 Stat. 748, provided that:

''(2) The amendments made by subsection (b) [amending this section] shall apply to annual notices beginning with 1989.

''(3) The amendments made by subsection (c) [amending this section] shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989.''

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(3)(A), (C)(i), (f)(1)(A), (B), (2)–(4)(C), (5), (6)(B), (7), (9), (11)(A), (14), (g)(2)(A)–(C), (i)(1)(A), (2), (4)(C)(vi), and (j)(4)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4031(a)(2) of Pub. L. 100–203 applicable to claims received on or after July 1, 1988, see section 4031(a)(3)(A) of Pub. L. 100–203, set out as a note under section 1395h of this title.

Amendment by section 4035(a)(2) of Pub. L. 100–203 effective Dec. 22, 1987, and applicable to budgets for fiscal years beginning with fiscal year 1989, see section 4035(a)(3) of Pub. L. 100–203, set out as a note under section 1395h of this title.

Pub. L. 100–203, title IV, §4044(b), Dec. 22, 1987, 101 Stat. 1330–86, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payment for physicians' services furnished on or after January 1, 1989.''

Pub. L. 100–203, title IV, §4045(d), Dec. 22, 1987, 101 Stat. 1330–88, provided that: ''The amendments made by this section [amending this section and sections 1395*l* and 1395w–1 of this title and amending provisions set out below] shall apply to items and services furnished on or after April 1, 1988, except the amendment made by subsection (c)(2)(B) [amending this section] shall apply to services furnished on or after January 1, 1988.''

Pub. L. 100–203, title IV, §4046(b), Dec. 22, 1987, 101 Stat. 1330–89, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, §4047(b), Dec. 22, 1987, 101 Stat. 1330–89, as amended by Pub. L. 100–360, title IV, §411(f)(6)(C), July 1, 1988, 102 Stat. 779, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to physicians who first furnish services to medicare beneficiaries on or after April 1, 1988.''

Pub. L. 100–203, title IV, §4051(c), Dec. 22, 1987, 101 Stat. 1330–94, provided that:

''(1) The amendment made by subsection (a) [amending this section] shall apply to diagnostic tests performed on or after April 1, 1988.

''(2) The Secretary of Health and Human Services shall complete the review and make an appropriate adjustment of prevailing charge levels under subsection (b) [set out below] for items and services furnished no later than January 1, 1989.''

Pub. L. 100–203, title IV, §4053(b), formerly §4052(b), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered and amended by Pub. L. 100–360, title IV, §411(f)(11)(B), (14), July 1, 1988, 102 Stat. 781, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to payment for services furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, §4054(c), formerly §4053(c), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered by Pub. L. 100–360, title IV, §411(f)(14), July 1, 1988, 102 Stat. 781, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to charges imposed for services furnished on or after April 1, 1988.''

Amendment by section 4063(a) of Pub. L. 100–203 applicable to items furnished on or after July 1, 1988, see section 4063(c) of Pub. L. 100–203, set out as a note under section 1395(*l*) of this title.

Pub. L. 100–203, title IV, §4081(c)(1), Dec. 22, 1987, 101 Stat. 1330–127, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to contracts with carriers for claims for items and services furnished by participating physicians and suppliers on or after January 1, 1989.''

Pub. L. 100–203, title IV, §4082(e)(3), Dec. 22, 1987, 101 Stat. 1330–129, provided that: ''The amendments made by subsection (c) [amending this section] shall apply to evaluation of performance of carriers under contracts entered into or renewed on or after October 1, 1988.''

Pub. L. 100–203, title IV, §4085(g)(2), Dec. 22, 1987, 101 Stat. 1330–131, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if included in section 9307(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].''

Pub. L. 100–203, title IV, §4085(i)(7), Dec. 22, 1987, 101 Stat. 1330–132, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4096(a)(1) of Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, §1895(b)(16)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to claims presented after the date of the enactment of this Act [Oct. 22, 1986].''

Amendment by section 1895(b)(14)(A), (15) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9307(c)(2), Oct. 21, 1986, 100 Stat. 1995, provided that the amendment made by section 9307(c)(2)(A) of Pub. L. 99–509 [amending directory language of section 1895(b)(14)(A)(ii) of Pub. L. 99–514 which amended this section] is effective as if included in the enactment of the Tax Reform Act of 1986, Pub. L. 99–514.

Amendment by section 9311(c) of Pub. L. 99–509 applicable to claims received on or after Nov. 1, 1986, with subsec. (c)(2)(C) of this section applicable to claims received on or after Apr. 1, 1987, see section 9311(d) of Pub. L. 99–509, set out as a note under section 1395h of this title.

Amendment by section 9320(e)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9331(a)(4), Oct. 21, 1986, 100 Stat. 2019, provided that: ''The amendments made by this subsection [amending this section] shall apply to services furnished on or after January 1, 1987.''

Pub. L. 99–509, title IX, §9331(b)(4), Oct. 21, 1986, 100 Stat. 2020, provided that: ''The amendments made by this subsection [amending this section] shall apply to services furnished on or after January 1, 1987.''

Pub. L. 99–509, title IX, §9331(c)(3)(B), Oct. 21, 1986, 100 Stat. 2021, provided that: ''The amendments made by

subparagraph (A) [amending this section] shall apply to physicians' services furnished on or after January 1, 1988.''

Pub. L. 99–509, title IX, § 9332(a)(4)(A), Oct. 21, 1986, 100 Stat. 2023, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective for contracts under section 1842 of the Social Security Act [42 U.S.C. 1395u] as of October 1, 1987.''

Pub. L. 99–509, title IX, § 9332(b)(3), Oct. 21, 1986, 100 Stat. 2023, provided that: ''The amendments made by this paragraph [probably means 'this subsection' which amended this section] shall first apply to directories for 1987.''

Pub. L. 99–509, title IX, § 9332(c)(2), Oct. 21, 1986, 100 Stat. 2024, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after October 1, 1987.''

Pub. L. 99–509, title IX, § 9332(d)(2), Oct. 21, 1986, 100 Stat. 2025, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to surgical procedures performed on or after October 1, 1987.''

Pub. L. 99–509, title IX, § 9333(d), Oct. 21, 1986, 100 Stat. 2028, provided that: ''The amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–509, title IX, § 9334(c), Oct. 21, 1986, 100 Stat. 2029, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 1987.''

Amendment by section 9338(b), (c) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1987, see section 9338(f) of Pub. L. 99–509 set out as a note under section 1395x of this title.

Amendment by section 9341(a)(2) of Pub. L. 99–509 applicable to items and services furnished on or after Jan. 1, 1987, see section 9341(b) of Pub. L. 99–509, set out as a note under section 1395ff of this title.

Pub. L. 99–272, title IX, § 9219(b)(1)(D), Apr. 7, 1986, 100 Stat. 183, provided that: ''The amendments made by this paragraph [amending this section and sections 1395x and 1395yy of this title] shall be effective as if they had been originally included in the Deficit Reduction Act of 1984 [Pub. L. 98–369].''

Pub. L. 99–272, title IX, § 9219(b)(2)(B), Apr. 7, 1986, 100 Stat. 183, provided that: ''The amendment made by subparagraph (A) [amending this section] shall be effective as if it had been originally included in Public Law 98–617.''

Pub. L. 99–272, title IX, § 9301(b)(4), Apr. 7, 1986, 100 Stat. 186, provided that: ''The amendments made by this subsection [amending this section and enacting provisions set out as a note under this section] shall apply to services furnished on or after May 1, 1986.''

Pub. L. 99–272, title IX, § 9301(c)(5), Apr. 7, 1986, 100 Stat. 187, as amended by Pub. L. 99–514, title XVIII, § 1895(b)(14)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: ''Section 1842(h)(7) of the Social Security Act [42 U.S.C. 1395u(h)(7)], as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than October 1, 1986) as the Secretary of Health and Human Services shall specify.''

Pub. L. 99–272, title IX, § 9301(d)(4), Apr. 7, 1986, 100 Stat. 188, provided that: ''The amendments made by this subsection [amending this section and enacting provisions set out as a note under this section] shall apply to items and services furnished on or after October 1, 1986.''

Pub. L. 99–272, title IX, § 9306(b), Apr. 7, 1986, 100 Stat. 193, provided that: ''The amendments made by this section [amending this section] shall apply to items and services furnished on or after April 1, 1986.''

Amendment by section 9307(c) of Pub. L. 99–272 applicable to services performed on or after April 1, 1986, see section 9307(e) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(e) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1), (3) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Pub. L. 98–369, div. B, title III, § 2306(b)(2), July 18, 1984, 98 Stat. 1071, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to items and services furnished on or after October 1, 1985.''

Pub. L. 98–369, div. B, title III, § 2307(a)(3), July 18, 1984, 98 Stat. 1073, provided that: ''The amendments made by this subsection [amending this section] shall apply to services furnished on or after July 1, 1984.''

Amendment by section 2326(d)(2) of Pub. L. 98–369 applicable to agreements and contracts entered into or renewed after Sept. 30, 1984, see section 2326(d)(3) of Pub. L. 98–369, set out as a note under section 1395h of this title.

Amendment by section 2354(b)(13), (14) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(iv) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, § 104(b), Sept. 3, 1982, 96 Stat. 337, as amended by Pub. L. 97–448, title III, § 309(a)(2), Jan. 12, 1983, 96 Stat. 2408, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after October 1, 1982.''

Pub. L. 97–248, title I, § 113(b)(1), Sept. 3, 1982, 96 Stat. 341, provided that: ''The amendment made by subsection (a) [amending this section] is effective with respect to services performed on or after October 1, 1982.''

Amendment by section 128(d)(1) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, § 918(a)(2), Dec. 5, 1980, 94 Stat. 2626, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to bills submitted and requests for payment made on or after such date (not later than April 1, 1981) as the Secretary of Health and Human Services prescribes by a notice published in the Federal Register.''

Pub. L. 96–499, title IX, § 946(c), Dec. 5, 1980, 94 Stat. 2643, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall become effective with respect to bills submitted or requests for payment made on or after July 1, 1981.''

Pub. L. 96–499, title IX, § 948(c)(2), Dec. 5, 1980, 94 Stat. 2645, provided that: ''The amendment made by subsection (b) [amending this section] shall apply with respect to cost accounting periods beginning on or after January 1, 1981.''

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective in the case of items and services furnished after Dec. 20, 1977, see section 501(c) of Pub. L. 95–216, set out as a note under section 1395x of this title.

Amendment by Pub. L. 95–142 applicable with respect to care and services furnished on or after Oct. 25, 1977,

see section 2(a)(4) of Pub. L. 95–142, set out as a note under section 1395g of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–368, § 4, July 16, 1976, 90 Stat. 997, provided that: ''The amendments made by sections 2 and 3 of this Act [amending this section and provisions set out as a note under section 390e of Title 7, Agriculture] shall be effective with respect to periods beginning after June 30, 1976; except that, for the twelve-month period beginning July 1, 1976, the amendments made by section 3 [amending this section and provisions set out as a note under section 390e of Title 7, Agriculture] shall be applicable with respect to claims filed under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] (after June 30, 1976, and before July 1, 1977) with a carrier designated pursuant to section 1842 of such Act [42 U.S.C. 1395u], and processed by such carrier after the appropriate changes were made pursuant to such section 3 in the prevailing charge levels for such twelve-month period under the third and fourth sentences of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)].''

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(c)(3) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 227(e)(3) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, § 236(c), Oct. 30, 1972, 86 Stat. 1415, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to bills submitted and requests for payments made after the date of the enactment of this Act [Oct. 30, 1972]. The amendments made by subsection (b) [amending section 1396a of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides).''

Pub. L. 92–603, title II, § 258(b), Oct. 30, 1972, 86 Stat. 1447, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to bills submitted and requests for payment made after March 1968.''

Pub. L. 92–603, title II, § 262(b), Oct. 30, 1972, 86 Stat. 1448, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the Social Security Act [42 U.S.C. 1395u(b)(3)(C)]) after the date of the enactment of this Act [Oct. 30, 1972].''

Amendment by section 263(d)(5) of Pub. L. 92–603 with respect to collection of premiums applicable to premiums becoming due and payable after the fourth month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 263(f) of Pub. L. 92–603, set out as a note under section 1395s of this title.

Amendment by section 281(d) of Pub. L. 92–603 to apply in the case of notices sent to individuals after 1968, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, § 125(b), Jan. 2, 1968, 81 Stat. 846, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to claims on which a final determination has not been made on or before the date of enactment of this Act [Jan. 2, 1968].''

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

PART B ADVANCE PAYMENTS

Pub. L. 116–159, div. C, title V, § 2501(a)(2), Oct. 1, 2020, 134 Stat. 735, provided that:

''(A) IN GENERAL.—In the case of a payment made under the terms of the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation) on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and so made during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall, upon request of the provider of services or supplier receiving such payment—

''(i) provide 1 year before payments for items and services furnished by such provider or supplier are offset to recoup payments under such program;

''(ii) provide that any such offset be an amount equal to—

''(I) during the first 11 months in which any such offsets are made with respect to payment for items and services furnished by such provider or supplier, 25 percent of the amount of such payment for such items and services; and

''(II) during the succeeding 6 months, 50 percent of the amount of such payment for such items and services; and

''(iii) allow 29 months from the date of the first payment under such program to such provider or supplier before requiring that the outstanding balance be paid in full.

''(B) LIMITATION ON FURTHER PART B ADVANCE PAYMENTS.—With respect to the period of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) beginning on the date of the enactment of this Act [Oct. 1, 2020], the total amount of payments made under the terms of the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation)—

''(i) for the portion of 2020 occurring during such period of the emergency period and for each year, shall not exceed $10,000,000;

''(ii) for each year beginning and ending during such period of the emergency period, shall not exceed $10,000,000; and

''(iii) for the last year beginning during such period of the emergency period, the portion of such last year occurring during such period of the emergency period, shall not exceed $10,000,000.''

LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION

Pub. L. 108–173, title III, § 303(f), Dec. 8, 2003, 117 Stat. 2253, provided that: ''The Secretary [of Health and Human Services] shall not implement the revisions in payment amounts for drugs and biologicals administered by physicians as a result of the amendments made by subsection (b) [amending this section] with respect to 2004 unless the Secretary concurrently makes adjustments to the practice expense payment adjustment under the amendments made by subsection (a) [amending section 1395w–4 of this title].''

CONTINUATION OF PAYMENT METHODOLOGY FOR RADIOPHARMACEUTICALS

Pub. L. 108–173, title III, § 303(h), Dec. 8, 2003, 117 Stat. 2253, provided that: ''Nothing in the amendments made by this section [enacting sections 1395w–3a and 1395w–3b

of this title, amending this section and sections 1395*l*, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for radiopharmaceuticals, including the use by carriers of invoice pricing methodology.''

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title III, § 303(i)(5), Dec. 8, 2003, 117 Stat. 2255, provided that: ''The provisions of chapter 8 of title 5, United States Code, shall not apply with respect to regulations implementing the amendments made by subsections (a), (b), and (e)(3) [sic] [amending this section and section 1395w–4 of this title], to regulations implementing section 304 [set out as a note under this section], and to regulations implementing the amendment made by section 305(a) [amending this section], insofar as such regulations apply in 2004.''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Pub. L. 108–173, title III, § 303(j), Dec. 8, 2003, 117 Stat. 2255, provided that: ''Insofar as the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] apply to payments for drugs or biologicals and drug administration services furnished by physicians, such amendments shall only apply to physicians in the specialties of hematology, hematology/oncology, and medical oncology under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

Pub. L. 108–173, title III, § 304, Dec. 8, 2003, 117 Stat. 2255, provided that: ''Notwithstanding section 303(j) [set out above], the amendments made by section 303 [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] shall also apply to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology.''

ISSUANCE OF TEMPORARY NATIONAL CODES

Pub. L. 108–173, title VII, § 731(c), Dec. 8, 2003, 117 Stat. 2351, provided that: ''Not later than July 1, 2004, the Secretary [of Health and Human Services] shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].''

REVISED PART B PAYMENT FOR DRUGS AND BIOLOGICALS AND RELATED SERVICES

Pub. L. 106–554, § 1(a)(6) [title IV, § 429], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that:

''(a) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

''(1) STUDY.—

''(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the reimbursement for drugs and biologicals under the current medicare payment methodology (provided under section 1842(*o*) of the Social Security Act (42 U.S.C. 1395u(*o*))) and for related services under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.]. In the study, the Comptroller General shall—

''(i) identify the average prices at which such drugs and biologicals are acquired by physicians and other suppliers;

''(ii) quantify the difference between such average prices and the reimbursement amount under such section; and

''(iii) determine the extent to which (if any) payment under such part is adequate to compensate physicians, providers of services, or other suppliers of such drugs and biologicals for costs incurred in the administration, handling, or storage of such drugs or biologicals.

''(B) CONSULTATION.—In conducting the study under subparagraph (A), the Comptroller General shall consult with physicians, providers of services, and suppliers of drugs and biologicals under the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.], as well as other organizations involved in the distribution of such drugs and biologicals to such physicians, providers of services, and suppliers.

''(2) REPORT.—Not later than 9 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress and to the Secretary of Health and Human Services a report on the study conducted under this subsection, and shall include in such report recommendations for revised payment methodologies described in paragraph (3).

''(3) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGIES.—

''(A) IN GENERAL.—The Comptroller General shall provide specific recommendations for revised payment methodologies for reimbursement for drugs and biologicals and for related services under the medicare program. The Comptroller General may include in the recommendations—

''(i) proposals to make adjustments under subsection (c) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the practice expense component of the physician fee schedule under such section for the costs incurred in the administration, handling, or storage of certain categories of such drugs and biologicals, if appropriate; and

''(ii) proposals for new payments to providers of services or suppliers for such costs, if appropriate.

''(B) ENSURING PATIENT ACCESS TO CARE.—In making recommendations under this paragraph, the Comptroller General shall ensure that any proposed revised payment methodology is designed to ensure that medicare beneficiaries continue to have appropriate access to health care services under the medicare program.

''(C) MATTERS CONSIDERED.—In making recommendations under this paragraph, the Comptroller General shall consider—

''(i) the method and amount of reimbursement for similar drugs and biologicals made by large group health plans;

''(ii) as a result of any revised payment methodology, the potential for patients to receive inpatient or outpatient hospital services in lieu of services in a physician's office; and

''(iii) the effect of any revised payment methodology on the delivery of drug therapies by hospital outpatient departments.

''(D) COORDINATION WITH BBRA STUDY.—In making recommendations under this paragraph, the Comptroller General shall conclude and take into account the results of the study provided for under section 213(a) of BBRA [Pub. L. 106–113, § 1000(a)(6) [title II, § 213(a)], set out as a note under section 1395*l* of this title] (113 Stat. 1501A–350).

''(b) IMPLEMENTATION OF NEW PAYMENT METHODOLOGY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, based on the recommendations contained in the report under subsection (a), the Secretary of Health and Human Services, subject to paragraph (2), shall revise the payment methodology under section 1842(*o*) of the Social Security Act (42 U.S.C. 1395u(*o*)) for drugs and biologicals furnished under part B of the medicare program [42 U.S.C. 1395j et seq.]. To the extent the Secretary determines appropriate, the Secretary may provide for the adjustments to payments amounts referred to in subsection (a)(3)(A)(i) or additional payments referred to in subsection (a)(2)(A)(ii).

''(2) LIMITATION.—In revising the payment methodology under paragraph (1), in no case may the estimated aggregate payments for drugs and biologicals under the revised system (including additional payments referred to in subsection (a)(3)(A)(ii)) exceed the aggregate amount of payment for such drugs and biologicals, as projected by the Secretary, that would have been made under the payment methodology in effect under such section 1842(*o*).

''(c) MORATORIUM ON DECREASES IN PAYMENT RATES.—Notwithstanding any other provision of law, effective for drugs and biologicals furnished on or after January 1, 2001, the Secretary may not directly or indirectly decrease the rates of reimbursement (in effect as of such date) for drugs and biologicals under the current medicare payment methodology (provided under section 1842(*o*) of the Social Security Act (42 U.S.C. 1395u(*o*))) until such time as the Secretary has reviewed the report submitted under subsection (a)(2).''

IMPLEMENTATION OF INHERENT REASONABLENESS (IR) AUTHORITY

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §223(a), (b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, 1501A–353, provided that:

''(a) LIMITATION ON USE.—The Secretary of Health and Human Services may not use, or permit fiscal intermediaries or carriers to use, the inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) until after—

''(1) the Comptroller General of the United States releases a report pursuant to the request for such a report made on March 1, 1999, regarding the impact of the Secretary's, fiscal intermediaries', and carriers' use of such authority; and

''(2) the Secretary has published a notice of final rulemaking in the Federal Register that relates to such authority and that responds to such report and to comments received in response to the Secretary's interim final regulation relating to such authority that was published in the Federal Register on January 7, 1998.

''(b) REEVALUATION OF IR CRITERIA.—In promulgating the final regulation under subsection (a)(2), the Secretary shall—

''(1) reevaluate the appropriateness of the criteria included in such interim final regulation for identifying payments which are excessive or deficient; and

''(2) take appropriate steps to ensure the use of valid and reliable data when exercising such authority.''

INITIAL BUDGET NEUTRALITY

Pub. L. 105–33, title IV, §4315(d), Aug. 5, 1997, 111 Stat. 390, provided that: ''The Secretary, in developing a fee schedule for particular services (under the amendments made by this section [amending this section and section 1395*l* of this title]), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if such fee schedule had not been implemented.''

IMPROVEMENTS IN ADMINISTRATION OF LABORATORY TESTS BENEFIT

Pub. L. 105–33, title IV, §4554, Aug. 5, 1997, 111 Stat. 460, provided that:

''(a) SELECTION OF REGIONAL CARRIERS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall—

''(A) divide the United States into no more than 5 regions, and

''(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to clinical diagnostic laboratory tests furnished on or after such date (not later than July 1, 1999) as the Secretary specifies.

''(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

''(A) a carrier's timeliness, quality, and experience in claims processing, and

''(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

''(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

''(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

''(5) SECRETARIAL EXCLUSION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory tests furnished by physician office laboratories if the Secretary determines that such offices would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

''(b) ADOPTION OF NATIONAL POLICIES FOR CLINICAL LABORATORY TESTS BENEFIT.—

''(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall first adopt, consistent with paragraph (2), national coverage and administrative policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

''(2) CONSIDERATIONS IN DESIGN OF NATIONAL POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

''(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

''(B) The medical conditions for which a laboratory test is reasonable and necessary (within the meaning of section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)]).

''(C) The appropriate use of procedure codes in billing for a laboratory test, including the unbundling of laboratory services.

''(D) The medical documentation that is required by a medicare contractor at the time a claim is submitted for a laboratory test in accordance with section 1833(e) of the Social Security Act [42 U.S.C. 1395*l*(e)].

''(E) Recordkeeping requirements in addition to any information required to be submitted with a claim, including physicians' obligations regarding such requirements.

''(F) Procedures for filing claims and for providing remittances by electronic media.

''(G) Limitation on frequency of coverage for the same tests performed on the same individual.

''(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF NATIONAL POLICY.—During the period that begins on the date of the enactment of this Act [Aug. 5, 1997] and ends on the date the Secretary first implements national policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

''(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such national policies,

the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary tests. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

''(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national policies of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

''(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the national policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the national policies previously adopted under this subsection.

''(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any policies adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

''(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by a carrier to advise such carrier with respect to coverage and administrative policies under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall include an individual to represent the independent clinical laboratories and such other laboratories as the Secretary deems appropriate. The Secretary shall consider recommendations from national and local organizations that represent independent clinical laboratories in such selection.''

WHOLESALE PRICE STUDY AND REPORT

Pub. L. 105–33, title IV, § 4556(c), Aug. 5, 1997, 111 Stat. 463, which directed the Secretary of Health and Human Services to study the effect on the average wholesale price of drugs and biologicals of the amendments to this section by section 4556(a) of Pub. L. 105–33, and to report to Congress the result of such study not later than July 1, 1999, was repealed by Pub. L. 108–173, title III, § 303(i)(6), Dec. 8, 2003, 117 Stat. 2255.

BUDGET NEUTRALITY ADJUSTMENT

Pub. L. 103–66, title XIII, § 13515(b), Aug. 10, 1993, 107 Stat. 583, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services shall reduce the following values and amounts for 1994 (to be applied for that year and subsequent years) by such uniform percentage as the Secretary determines to be required to assure that the amendments made by subsection (a) [amending this section and section 1395w–4 of this title] will not result in expenditures under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in 1994 that exceed the amount of such expenditures that would have been made if such amendments had not been made:

''(1) The relative values established under section 1848(c) of such Act [42 U.S.C. 1395w–4(c)] for services (other than anesthesia services) and, in the case of anesthesia services, the conversion factor established under section 1848 of such Act for such services.

''(2) The amounts determined under section 1848(a)(2)(B)(ii)(I) of such Act.

''(3) The prevailing charges or fee schedule amounts to be applied under such part for services of a health care practitioner (as defined in section 1842(b)(4)(F)(ii)(I) of such Act [42 U.S.C. 1395u(b)(4)(F)(ii)(I)], as in effect before the date of the enactment of this Act [Aug. 10, 1993]).''

PROCEDURE CODES

Pub. L. 101–508, title IV, § 4101(b)(2), Nov. 5, 1990, 104 Stat. 1388–55, as amended by Pub. L. 103–432, title I, § 126(a)(2), Oct. 31, 1994, 108 Stat. 4414, provided that: ''In applying section 1842(b)(16)(B) of the Social Security Act [42 U.S.C. 1395u(b)(16)(B)]:

''(A) The codes for the procedures specified in clause (ii) are as follows: Hospital inpatient medical services (HCPCS codes 90200 through 90292), consultations (HCPCS codes 90600 through 90654), other visits (HCPCS code 90699), preventive medicine visits (HCPCS codes 90750 through 90764), psychiatric services (HCPCS codes 90801 through 90862), emergency care facility services (HCPCS codes 99062 through 99065), and critical care services (HCPCS codes 99160 through 99174).

''(B) The codes for the procedures specified in clause (iii) are as follows: Partial mastectomy (HCPCS code 19160); tendon sheath injections and small joint arthrocentesis (HCPCS codes 20550, 20600, 20605, and 20610); femoral fracture and trochanteric fracture treatments (HCPCS codes 27230, 27232, 27234, 27238, 27240, 27242, 27246, and 27248); endotracheal intubation (HCPCS code 31500); thoracentesis (HCPCS code 32000); thoracostomy (HCPCS codes 32020, 32035, and 32036); aneurysm repair (HCPCS codes 35111); cystourethroscopy (HCPCS code 52340); transurethral fulguration and resection (HCPCS codes 52606 and 52620); tympanoplasty with mastoidectomy (HCPCS code 69645); and ophthalmoscopy (HCPCS codes 92250 and 92260).''

STUDY OF RELEASE OF PREPAYMENT MEDICAL REVIEW SCREEN PARAMETERS

Pub. L. 101–508, title IV, § 4111, Nov. 5, 1990, 104 Stat. 1388–64, directed Secretary of Health and Human Services to conduct a study of effect of release of medicare prepayment medical review screen parameters on physician billings for services to which the parameters apply, such study to be based upon the release of the screen parameters at a minimum of six carriers, with Secretary to report results of study to Congress not later than Oct. 1, 1992.

FREEZE IN CHARGES FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT

Pub. L. 103–66, title XIII, § 13541, Aug. 10, 1993, 107 Stat. 587, provided that: ''In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to parenteral and enteral nutrients, supplies, and equipment during 1994 and 1995, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1993.''

Pub. L. 101–508, title IV, § 4152(d), Nov. 5, 1990, 104 Stat. 1388–79, provided that: ''In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for enteral and parenteral nutrients, supplies, and equipment furnished during 1991, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such items for 1990.''

PROHIBITION ON REGULATIONS CHANGING COVERAGE OF CONVENTIONAL EYEWEAR

Pub. L. 101–508, title IV, § 4153(b)(1), Nov. 5, 1990, 104 Stat. 1388–84, provided that:

''(A) Notwithstanding any other provision of law (except as provided in subparagraph (B)) the Secretary of Health and Human Services (referred to in this subsection as the 'Secretary') may not issue any regulation that changes the coverage of conventional eyewear furnished to individuals (enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]) following cataract surgery with insertion of an intraocular lens.

''(B) Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing the amendments made by paragraph (2).''

DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS

Pub. L. 101–508, title IV, §4164(c), Nov. 5, 1990, 104 Stat. 1388–102, as amended by Pub. L. 103–432, title I, §147(f)(7)(B), Oct. 31, 1994, 108 Stat. 4432, provided that: ''Not later than March 31, 1991, the Secretary of Health and Human Services shall publish, and shall periodically update, a directory of the unique physician identification numbers of all physicians providing services for which payment may be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall include in such directory the names, provider numbers, and billing addressess [sic] of all listed physicians.''

TREATMENT OF CERTAIN EYE EXAMINATION VISITS AS PRIMARY CARE SERVICES

Pub. L. 101–239, title VI, §6102(e)(10), Dec. 19, 1989, 103 Stat. 2188, provided that: ''In applying section 1842(i)(4) of the Social Security Act [42 U.S.C. 1395u(i)(4)] for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services.''

DELAY IN UPDATE UNTIL APRIL 1, 1990, AND REDUCTION IN PERCENTAGE INCREASE IN MEDICARE ECONOMIC INDEX

Pub. L. 101–239, title VI, §6107(a), Dec. 19, 1989, 103 Stat. 2211, provided that:

''(1) IN GENERAL.—Subject to the amendments made by this section [amending this section], any increase or adjustment in customary, prevailing, or reasonable charges, fee schedule amounts, maximum allowable actual charges, and other limits on actual charges with respect to physicians' services and other items and services described in paragraph (2) under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] which would otherwise occur as of January 1, 1990, shall be delayed so as to occur as of April 1, 1990, and, notwithstanding any other provision of law, the amount of payment under such part for such items and services which are furnished during the period beginning on January 1, 1990, and ending on March 31, 1990, shall be determined on the same basis as the amount of payment for such services furnished on December 31, 1989.

''(2) ITEMS AND SERVICES COVERED.—The items and services described in this paragraph are items and services (other than ambulance services and clinical diagnostic laboratory services) for which payment is made under part B of title XVIII of the Social Security Act on the basis of a reasonable charge or a fee schedule.

''(3) EXTENSION OF PARTICIPATION AGREEMENTS AND RELATED PROVISIONS.—Notwithstanding any other provision of law—

''(A) subject to the last sentence of this paragraph, each participation agreement in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] shall remain in effect for the 3-month period beginning on January 1, 1990;

''(B) the effective period for such agreements under such section entered into for 1990 shall be the 9-month period beginning on April 1, 1990, and the Secretary of Health and Human Services shall provide an opportunity for physicians and suppliers to enroll as participating physicians and suppliers before April 1, 1990;

''(C) instead of publishing, under section 1842(h)(4) of the Social Security Act [42 U.S.C. 1395u(h)(4)], at the beginning of 1990, directories of participating physicians and suppliers for 1990, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1990, of such directories of participating physicians and suppliers for such period; and

''(D) instead of providing to nonparticipating physicians under section 1842(b)(3)(G) of the Social Security Act [42 U.S.C. 1395u(b)(3)(G)] at the beginning of 1990, a list of maximum allowable actual charges for 1990, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1990, such physicians such a list for such 9-month period.

An agreement with a participating physician or supplier described in subparagraph (A) in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician or supplier requests on or before December 31, 1989, that the agreement be terminated.''

STATE DEMONSTRATION PROJECTS ON APPLICATION OF LIMITATION ON VISITS PER MONTH PER RESIDENT ON AGGREGATE BASIS FOR A TEAM

Pub. L. 101–239, title VI, §6114(e), Dec. 19, 1989, 103 Stat. 2218, provided that: ''The Secretary of Health and Human Services shall provide for at least 1 demonstration project under which, in the application of section 1842(b)(2)(C) of the Social Security Act [42 U.S.C. 1395u(b)(2)(C)] (as added by subsection (c)(2) of this section) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team.''

APPLICATION OF DIFFERENT PERFORMANCE STANDARDS FOR ELECTRONIC SYSTEM FOR COVERED OUTPATIENT DRUGS

Pub. L. 100–360, title II, §202(e)(3)(B), July 1, 1988, 102 Stat. 717, as amended by Pub. L. 100–485, title VI, §608(d)(5)(E), Oct. 13, 1988, 102 Stat. 2414, which required Secretary of Health and Human Services, before entering into contracts under section 1395u of this title with respect to implementation and operation of electronic system for covered outpatient drugs, to establish standards with respect to performance with respect to such activities, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

DELAY IN APPLICATION OF COORDINATION OF BENEFITS WITH PRIVATE HEALTH INSURANCE

Pub. L. 100–360, title II, §202(e)(4)(B), July 1, 1988, 102 Stat. 717, which provided that the provisions of section 1395u(h)(3) of this title not apply to covered outpatient drugs (other than drugs described in section 1395x(s)(2)(J) of this title as of July 1, 1988) dispensed before January 1, 1993, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

EXTENSION OF PHYSICIAN PARTICIPATION AGREEMENTS AND RELATED PROVISIONS

Pub. L. 100–203, title IV, §4041(a)(2), Dec. 22, 1987, 101 Stat. 1330–83, provided that: ''Notwithstanding any other provision of law—

''(A) subject to the last sentence of this paragraph, each agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] shall remain in effect for the 3-month period beginning on January 1, 1988;

''(B) the effective period for agreements under such section entered into for 1988 shall be the nine-month period beginning on April 1, 1988, and the Secretary shall provide an opportunity for physicians to enroll as participating physicians prior to April 1, 1988;

''(C) instead of publishing, under section 1842(h)(4) of the Social Security Act [42 U.S.C. 1395u(h)(4)] at

the beginning of 1988, directories of participating physicians for 1988, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1988, of such directories of participating physicians for such period; and

''(D) instead of providing to nonparticipating physicians, under section 1842(b)(3)(G) of the Social Security Act [42 U.S.C. 1395u(b)(3)(G)] at the beginning of 1988, a list of maximum allowable actual charges for 1988, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1988, to such physicians such a list for such 9-month period.

An agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician requests on or before December 31, 1987, that the agreement be terminated.''

DEVELOPMENT OF UNIFORM RELATIVE VALUE GUIDE

Pub. L. 100–203, title IV, § 4048(b), Dec. 22, 1987, 101 Stat. 1330–90, as amended by Pub. L. 101–508, title IV, § 4118(h)(1), Nov. 5, 1990, 104 Stat. 1388–70, provided that: ''The Secretary of Health and Human Services, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] on and after March 1, 1989. Such guide shall be designed so as to result in expenditures under such title [42 U.S.C. 1395 et seq.] for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.''

[Pub. L. 101–508, title IV, § 4118(h), Nov. 5, 1990, 104 Stat. 1388–70, provided that the amendment by that section to section 4048(b) of Pub. L. 100–203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.]

STUDY OF PREVAILING CHARGES FOR ANESTHESIA SERVICES

Pub. L. 100–203, title IV, § 4048(c), Dec. 22, 1987, 101 Stat. 1330–90, which required Secretary of Health and Human Services to study variations in conversion factors used by carriers under section 1395u(b) of this title to determine prevailing charge for anesthesia services and to report results of study and make recommendations for appropriate adjustments in such factors not later than Jan. 1, 1989, was repealed by Pub. L. 101–508, title IV, § 4118(g)(2), Nov. 5, 1990, 104 Stat. 1388–70.

GAO STUDIES

Pub. L. 100–203, title IV, § 4048(d), Dec. 22, 1987, 101 Stat. 1330–90, provided that:

''(1) The Comptroller General shall conduct a study—

''(A) to determine the average anesthesia times reported for medicare reimbursement purposes,

''(B) to verify those times from patient medical records,

''(C) to compare anesthesia times to average surgical times, and

''(D) to determine whether the current payments for physician supervision of nurse anesthetists are excessive.

The Comptroller General shall report to Congress, by not later than January 1, 1989, on such study and in the report include recommendations regarding the appropriateness of the anesthesia times recognized by medicare for reimbursement purposes and recommendations regarding adjustments of payments for physician supervision of nurse anesthetists.

''(2) The Comptroller General shall conduct a study on the impact of the amendment made by subsection (a) [amending this section], and shall report to Congress on the results of such study by April 1, 1990.''

ADJUSTMENT IN MEDICARE PREVAILING CHARGES

Pub. L. 100–203, title IV, § 4051(b), Dec. 22, 1987, 101 Stat. 1330–94, provided that:

''(1) REVIEW.—The Secretary of Health and Human Services shall review payment levels under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for diagnostic tests (described in section 1861(s)(3) of such Act [42 U.S.C. 1935x(s)(3)], but excluding clinical diagnostic laboratory tests) which are commonly performed by independent suppliers, sold as a service to physicians, and billed by such physicians, in order to determine the reasonableness of payment amounts for such tests (and for associated professional services component of such tests). The Secretary may require physicians and suppliers to provide such information on the purchase or sale price (net of any discounts) for such tests as is necessary to complete the review and make the adjustments under this subsection. The Secretary shall also review the reasonableness of payment levels for comparable in-office diagnostic tests.

''(2) ESTABLISHMENT OF REVISED PAYMENT SCREENS.—If, as a result of such review, the Secretary determines, after notice and opportunity of at least 60 days for public comment, that the current prevailing charge levels (under the third and fourth sentences of section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)]) for any such tests or associated professional services are excessive, the Secretary shall establish such charge levels at levels which, consistent with assuring that the test is widely and consistently available to medicare beneficiaries, reflect a reasonable price for the test without any markup. Alternatively, the Secretary, pursuant to guidelines published after notice and opportunity of at least 60 days for public comment, may delegate to carriers with contracts under section 1842 of the Social Security Act the establishment of new prevailing charge levels under this paragraph. When such charge levels are established, the provisions of section 1842(j)(1)(D) of such Act shall apply in the same manner as they apply to a reduction under section 1842(b)(8)(A) of such Act.''

ADJUSTMENT FOR MAXIMUM ALLOWABLE ACTUAL CHARGE

Pub. L. 100–203, title IV, § 4054(b), formerly § 4053(b), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered by Pub. L. 100–360, title IV, § 411(f)(14), July 1, 1988, 102 Stat. 781, provided that: ''In the case of a physician who did not have actual charges under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for a procedure in the calendar quarter beginning on April 1, 1984, but who establishes to the satisfaction of a carrier that he or she had actual charges (whether under such title or otherwise) for the procedure performed prior to June 30, 1984, the carrier shall compute the maximum allowable actual charge under section 1842(j) of the Social Security Act [42 U.S.C. 1395u(j)] for such procedure performed by such physician in 1988 based on such physician's actual charges for the procedure.''

PHYSICIAN PAYMENT STUDIES; DEFINITIONS OF MEDICAL AND SURGICAL PROCEDURES

Pub. L. 100–203, title IV, § 4056(a), formerly § 4055(a), Dec. 22, 1987, 101 Stat. 1330–98, as renumbered and amended by Pub. L. 100–360, title IV, § 411(f)(13)(A), (14), July 1, 1988, 102 Stat. 781; Pub. L. 101–508, title IV, § 4118(g)(4), Nov. 5, 1990, 104 Stat. 1388–70, provided that:

''(1) REPORT ON VARIATIONS IN CARRIER PAYMENT PRACTICE.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study of variations in payment practices for physicians' services among the different carriers under section 1842 of the Social Security Act [42 U.S.C. 1395u]. Such study shall examine carrier variations in the services included in global fees and pre- and post-operative services included in payment for the operation.

''(2) UNIFORM DEFINITIONS OF PROCEDURES FOR PAYMENT PURPOSES.—The Secretary shall develop, in consultation with appropriate national medical specialty societies and by not later than July 1, 1989, uniform definitions of physicians' services (including appropriate classification scheme for procedures) which could serve as the basis for making payments for such

services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]. In developing such definitions, to the extent practicable—

''(A) ancillary services commonly performed in conjunction with a major procedure would be included with the major procedure;

''(B) pre- and post-procedure services would be included in the procedure; and

''(C) similar procedures would be listed together if the procedures are similar in resource requirements.''

PAYMENTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS; 1-YEAR FREEZE ON CHARGE LIMITATIONS

Pub. L. 100–203, title IV, §4062(a), Dec. 22, 1987, 101 Stat. 1330–100, provided that:

''(1) IN GENERAL.—In imposing limitations on allowable charges for items and services (other than physicians' services) furnished in 1988 under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] and for which payment is made on the basis of the reasonable charge for the item or service, the Secretary of Health and Human Services shall not impose any limitation at a level higher than the same level as was in effect in December 1987.

''(2) TRANSITION.—The provisions of section 4041(a)(2) (other than subparagraph (D) thereof) of this subtitle [set out as a note above] shall apply to suppliers of items and services described in paragraph (1), and directories of participating suppliers of such items and services, in the same manner as such section applies to physicians furnishing physicians' services, and directories of participating physicians.''

SPECIAL RULE WITH RESPECT TO PAYMENT FOR INTRAOCULAR LENSES

Pub. L. 100–203, title IV, §4063(d), Dec. 22, 1987, 101 Stat. 1330–110, provided that: ''With respect to the establishment of a reasonable charge limit under section 1842(b)(11)(C)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(11)(C)(ii)], in applying section 1842(j)(1)(D)(i) of such Act, the matter beginning with 'plus' shall be considered to have been deleted.''

STUDY ON COST EFFECTIVENESS OF HEARING PRIOR TO HEARING BY ADMINISTRATIVE LAW JUDGE ON CARRIER DETERMINATIONS; REPORT TO CONGRESS

Pub. L. 100–203, title IV, §4082(d), Dec. 22, 1987, 101 Stat. 1330–128, provided that: ''The Comptroller General shall conduct a study concerning the cost effectiveness of requiring hearings with a carrier under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] before having a hearing before an administrative law judge respecting carrier determinations under that part. The Comptroller General shall report to the Congress on the results of such study by not later than June 30, 1989.''

CAPACITY TO SET GEOGRAPHIC PAYMENT LIMITS

Pub. L. 100–203, title IV, §4085(e), Dec. 22, 1987, 101 Stat. 1330–131, provided that: ''The Secretary of Health and Human Services shall develop the capability to implement (for services furnished on or after January 1, 1989) geographic limits on charges and payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services based on statewide, regional, or national average (or percentile in a distribution) of prevailing charges or payment amounts (weighted by frequency of services). Any such limits shall take into account adjustments for geographic differences in cost of practice and cost of living.''

UTILIZATION SCREENS FOR PHYSICIAN SERVICES PROVIDED TO PATIENTS IN REHABILITATION HOSPITALS

Pub. L. 101–508, title IV, §4114, Nov. 5, 1990, 104 Stat. 1388–65, as amended by Pub. L. 103–432, title I, §126(g)(4), Oct. 31, 1994, 108 Stat. 4416, provided that: ''Not later than 180 days after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services shall issue guidelines to assure a uniform level of review of physician visits to patients of a rehabilitation hospital or unit after the medical review screen parameter established under section 4085(h) of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, set out below] has been exceeded.''

Pub. L. 100–203, title IV, §4085(h), Dec. 22, 1987, 101 Stat. 1330–131, provided that:

''(1) The Secretary of Health and Human Services shall establish (in consultation with appropriate physician groups, including those representing rehabilitative medicine) a separate utilization screen for physician visits to patients in rehabilitation hospitals and rehabilitative units (and patients in long-term care hospitals receiving rehabilitation services) to be used by carriers under section 1842 of the Social Security Act [42 U.S.C. 1395u] in performing functions under subsection (a) of such section related to the utilization practices of physicians in such hospitals and units.

''(2) Not later than 12 months after the date of enactment of this Act [Dec. 22, 1987], the Secretary of Health and Human Services shall take appropriate steps to implement the utilization screen established under paragraph (1).''

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

AMENDMENTS IN CONTRACTS AND REGULATIONS

The Secretary of Health and Human Services to provide for such timely amendments to contracts under this section, and regulations, to such extent as may be necessary to implement Pub. L. 99–509 on a timely basis, see section 9311(d)(3) of Pub. L. 99–509, set out as an Effective Date of 1986 Amendment note under section 1395h of this title.

MEDICARE ECONOMIC INDEX

Pub. L. 99–509, title IX, §9331(c)(1), (2), (4)–(6), Oct. 21, 1986, 100 Stat. 2020, 2021, provided that:

''(1) FOR 1987.—Notwithstanding any other provision of law, for purposes of part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services furnished in 1987, the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(4)(E)(ii)]) shall be 3.2 percent.

''(2) PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.—The Secretary of Health and Human Services is not authorized to revise the MEI in a manner that provides, for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.''

''(4) STUDY.—The Secretary shall conduct a study of the extent to which the MEI appropriately and equitably reflects economic changes in the provision of the physicians' services to medicare beneficiaries. In conducting such study the Secretary shall consult with appropriate experts.

''(5) LIMITATION ON CHANGES IN MEI METHODOLOGY.—The Secretary shall not change the methodology (including the basis and elements) used in the MEI from that in effect as of October 1, 1985, until completion of the study under paragraph (4). After the completion of the study, the Secretary may not change such methodology except after providing notice in the Federal Register and opportunity for public comment.

''(6) MEI DEFINED.—In this subsection, the term 'MEI' means the economic index referred to in the fourth sen-

tence of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)].''

DEVELOPMENT AND USE OF HCFA COMMON PROCEDURE CODING SYSTEM

Pub. L. 99–509, title IX, § 9331(d), Oct. 21, 1986, 100 Stat. 2021, provided that:

''(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary'), after public notice and opportunity for public comment and after consulation [consultation] with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

''(2) Not later than January 1, 1990, each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act [42 U.S.C. 1395u] shall make payments under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] based on the grouping of procedure codes effected under paragraph (1).''

MEASURING CARRIER PERFORMANCE; CARRIER BONUSES FOR GOOD PERFORMANCE

Pub. L. 99–509, title IX, § 9332(a)(2), (3), Oct. 21, 1986, 100 Stat. 2022, as amended by Pub. L. 100–203, title IV, § 4085(i)(21)(B), Dec. 22, 1987, 101 Stat. 1330–133, which provided that the Secretary of Health and Human Services was to provide, in the standards and criteria established under section 1842(b)(2) of the Social Security Act [42 U.S.C. 1395u(b)(2)] for contracts under that section, a system to measure a carrier's performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act and that, of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], the Secretary of Health and Human Services was to provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who were participating physicians or in increasing the proportion of total payments for physicians' services which were payments for such services rendered by participating physicians, was repealed by Pub. L. 100–203, title IV, § 4041(a)(3)(B)(i), Dec. 22, 1987, 101 Stat. 1330–84.

Pub. L. 99–509, title IX, § 9332(a)(4)(B), (C), Oct. 21, 1986, 100 Stat. 2023, as amended by Pub. L. 100–203, title IV, § 4041(a)(3)(B)(ii), (iii), Dec. 22, 1987, 101 Stat. 1330–84; Pub. L. 100–360, title IV, § 411(f)(1)(C), July 1, 1988, 102 Stat. 776, provided that:

''(B) PERFORMANCE MEASURES.—The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under the last sentence of section 1842(b)(2) of the Social Security Act [42 U.S.C. 1395u(b)(2)] by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

''(C) CARRIER BONUSES.—From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under section 1842(c)(1)(B) of the Social Security Act [42 U.S.C. 1395u(c)(1)(B)] not later than September 30, 1988, to reflect performance of carriers during the enrollment period before April 1, 1988.''

REVIEW OF PROCEDURES

Pub. L. 99–509, title IX, § 9333(c), Oct. 21, 1986, 100 Stat. 2028, provided that: ''Not later than October 1, 1987, the Secretary of Health and Human Services shall review the inherent reasonableness of the reasonable charges for at least 10 of the most costly procedures with respect to which payment is made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] (determined on the basis of the aggregate annual payments under such part with respect to each such procedure).''

RATIFICATION OF REGULATIONS

Pub. L. 99–509, title IX, § 9334(b), Oct. 21, 1986, 100 Stat. 2028, as amended by Pub. L. 100–203, title IV, § 4045(c)(2)(C), Dec. 22, 1987, 101 Stat. 1330–88, provided that:

''(1) IN GENERAL.—The Congress hereby ratifies the final regulation of the Secretary of Health and Human Services published on page 35693 of volume 51 of the Federal Register on October 7, 1986, relating to reasonable charge payment limits for anesthesia services under the medicare program.

''(2) PATIENT PROTECTIONS.—In the case of any reduction in the reasonable charge for physicians' services effected under the regulation described in paragraph (1), the provisions of section 1842(j)(1)(D) of the Social Security Act [42 U.S.C. 1395u(j)(1)(D)] (added by the amendment made by subsection (a)(3)) shall apply in the same manner and to the same extent as they apply to a reduction in the reasonable charge for a physicians' service effected under section 1842(b)(8) of such Act.''

PAYMENT FOR PARENTERAL AND ENTERAL NUTRITION SUPPLIES AND EQUIPMENT

Pub. L. 99–509, title IX, § 9340, Oct. 21, 1986, 100 Stat. 2037, provided that: ''The Secretary of Health and Human Services shall apply the sixth sentence of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)] to payment—

''(1) for enteral nutrition nutrients, supplies, and equipment and parenteral nutrition supplies and equipment furnished on or after January 1, 1987, and

''(2) for parenteral nutrition nutrients furnished on or after October 1, 1987.''

REPORTING OF OPD SERVICES USING HCPCS

Pub. L. 99–509, title IX, § 9343(g), Oct. 21, 1986, 100 Stat. 2041, provided that: ''Not later than July 1, 1987, each fiscal intermediary which processes claims under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall require hospitals, as a condition of payment for outpatient hospital services under that part, to report claims for payment for such services under such part using a HCFA Common Procedure Coding System.''

PERIOD FOR ENTERING INTO PARTICIPATION AGREEMENTS

Pub. L. 99–272, title IX, § 9301(b)(3), Apr. 7, 1986, 100 Stat. 186, provided that: ''The Secretary of Health and Human Services shall provide, during the month of April 1986, that physicians and suppliers may enter into an agreement under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] for the 8-month period beginning May 1, 1986, or terminate such an agreement previously entered into for fiscal year 1986. In the case of a physician or supplier who entered into such an agreement for fiscal year 1986, the physician or supplier shall be deemed to have entered into such agreement for such 8-month period and for each succeeding year unless the physician or supplier terminates such agreement before the beginning of the respective period. At the beginning of such 8-month period, the Secretary shall publish a new directory (described in section 1842(h)(4) of that Act [42 U.S.C. 1395u(h)(4)], as redesignated by subsection (c)(3)(D) of this section) of participating physicians and suppliers.''

TRANSITIONAL PROVISIONS FOR MEDICARE PART B PAYMENTS

Pub. L. 99–272, title IX, § 9301(d)(5), Apr. 7, 1986, 100 Stat. 188, provided that: ''Notwithstanding any other provision of law, for purposes of making payment under part B of title XVIII of the Social Security Act [42

U.S.C. 1395j et seq.], customary and prevailing charges (and the lowest charges determined under the sixth sentence of section 1842(b)(3) of such Act [42 U.S.C. 1395u(b)(3)]) for items and services furnished during the period beginning on October 1, 1986, and ending on December 31, 1986, shall be determined on the same basis as for items and services furnished on September 30, 1986.''

COMPUTATION OF CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS

Pub. L. 99–272, title IX, §9304(b), Apr. 7, 1986, 100 Stat. 190, provided that:

''(1) In applying section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)] to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who at anytime during the period beginning on October 31, 1982, and ending on January 31, 1985, was a hospital-compensated physician (as defined in paragraph (3)) but who, as of February 1, 1985, was no longer a hospital-compensated physician, the physician's customary charges shall—

''(A) be based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985, and

''(B) in the case of a physician who was not a participating physician (as defined in section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)]) on September 30, 1985, and who is not such a physician on May 1, 1986, be deflated (to take into account the legislative freeze on actual charges for nonparticipating physicians' services) by multiplying the physician's customary charges by .85.

''(2) In applying section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)] to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who during the period beginning on February 1, 1985, and ending on December 31, 1986, changes from being a hospital-compensated physician to not being a hospital-compensated physician, the physician's customary charges shall be determined in the same manner as if the physician were considered to be a new physician.

''(3) In this subsection, the term 'hospital-compensated physician' means, with respect to services furnished to patients of a hospital, a physician who is compensated by the hospital for the furnishing of physicians' services for which payment may be made under this part.''

EXTENSION OF MEDICARE PHYSICIAN PAYMENT PROVISIONS

Period of 15 months referred to in subsec. (j)(1) of this section for monitoring the charges of nonparticipating physicians to be deemed to include the period Oct. 1, 1985, to Mar. 14, 1986, see section 5(b) of Pub. L. 99–107, set out as a note under section 1395ww of this title.

SIMPLIFICATION OF PROCEDURES WITH RESPECT TO CLAIMS AND PAYMENTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 98–369, div. B, title III, §2303(h), July 18, 1984, 98 Stat. 1066, provided that: ''The Secretary of Health and Human Services shall simplify the procedures under section 1842 of the Social Security Act [42 U.S.C. 1395u] with respect to claims and payments for clinical diagnostic laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient information is supplied to identify instances of fraud and abuse.''

STUDY OF AMOUNTS BILLED FOR PHYSICIAN SERVICES AND PAID BY CARRIERS UNDER SUBSECTION (b)(7) OF THIS SECTION; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2307(c), July 18, 1984, 98 Stat. 1074, directed Comptroller General to conduct a study of the amounts billed for physician services and paid by carriers under subsec. (b)(7) of this section to determine whether such payments were made only where the physician satisfied the requirements of subsec. (b)(7)(A)(i) of this section, and to submit to Congress a report on results of such study not later than 18 months after July 18, 1984.

REPLACEMENT OF AGENCY, ORGANIZATION, OR CARRIER PROCESSING MEDICARE CLAIMS; NUMBER OF AGREEMENTS AND CONTRACTS AUTHORIZED FOR FISCAL YEARS 1985 THROUGH 1993

For provision authorizing two agreements under section 1395h of this title and two contracts under this section for replacement of an agency, organization, or carrier in the lowest 20th percentile, see section 2326(a) of Pub. L. 98–369, as amended, set out as a note under 1395h of this title.

RULES AND REGULATIONS

Pub. L. 97–248, title I, §113(b)(2), Sept. 3, 1982, 96 Stat. 341, provided that: ''The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement the amendment made by subsection (a) [amending this section] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983.''

REPORT ON REIMBURSEMENT OF CLINICAL LABORATORIES

Pub. L. 96–499, title IX, §918(a)(3), Dec. 5, 1980, 94 Stat. 2626, provided that not later than 24 months after an effective date (not later than Apr. 1, 1981) which was to have been prescribed by the Secretary of Health and Human Services, the Secretary was to report to the Congress (A) the proportion of bills and requests for payment submitted (during the 18-month period beginning on such effective date) under this subchapter for laboratory tests which did not identify who performed the tests, (B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under this subchapter was less than the amount that would otherwise have been payable in the absence of subsec. (h) of this section, (C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such subsec. (h), and (D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such subsec. (h).

PREVAILING CHARGE LEVELS FOR FISCAL YEAR BEGINNING JULY 1, 1975

Pub. L. 94–182, title I, §101(b), Dec. 31, 1975, 89 Stat. 1051, provided that: ''The amendment made by subsection (a) [amending subsec. (b)(3) of this section] shall be applicable with respect to claims filed under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with a carrier designated pursuant to section 1842 of such Act [42 U.S.C. 1395u] and processed by such carrier after the appropriate changes were made in the prevailing charge levels for the fiscal year beginning July 1, 1975, on the basis of economic index data under the third and fourth sentences of section 1842(b)(3) of such Act [42 U.S.C. 1395u(b)(3)]; except that (1) if less than the correct amount was paid (after the application of subsection (a) of this section) on any claim processed prior to the enactment of this section [Dec. 31, 1975], the correct amount shall be paid by such carrier at such time (not exceeding 6 months after the date of the enactment of this section) [Dec. 31, 1975] as is administratively feasible, and (2) no such payment shall be made on any claim where the difference be-

tween the amount paid and the correct amount due is less than $1.''

REPORT BY HEALTH INSURANCE BENEFITS ADVISORY COUNCIL ON METHODS OF REIMBURSEMENT OF PHYSICIANS FOR THEIR SERVICES

Pub. L. 92–603, title II, § 224(b), Oct. 30, 1972, 86 Stat. 1395, directed Health Insurance Benefits Advisory Council to conduct a study of methods of reimbursement for physicians' services under Medicare with respect to fees, extent of assignments accepted by physicians, and share of physician-fee costs which Medicare program does not pay and submit such study to Congress by Jan. 1, 1973.

Executive Documents

EXECUTIVE ORDER NO. 13947

Ex. Ord. No. 13947, July 24, 2020, 85 F.R. 59171, which related to a payment model pursuant to which Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price, was revoked by Ex. Ord. No. 13948, § 5, Sept. 13, 2020, 85 F.R. 59650, set out below.

EX. ORD. NO. 13948. LOWERING DRUG PRICES BY PUTTING AMERICA FIRST

Ex. Ord. No. 13948, Sept. 13, 2020, 85 F.R. 59649, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Americans pay more per capita for prescription drugs than residents of any other developed country in the world. It is unacceptable that Americans pay more for the exact same drugs, often made in the exact same places. Other countries' governments regulate drug prices by negotiating with drug manufacturers to secure bargain prices, leaving Americans to make up the difference—effectively subsidizing innovation and) [sic] lower-cost drugs for the rest of the world. The Council of Economic Advisers has found that Americans finance much of the biopharmaceutical innovation that the world depends on, allowing foreign governments, many of which are the sole healthcare payers in their respective countries, to enjoy bargain prices for such innovations. Americans should not bear extra burdens to compensate for the shortfalls that result from the nationalized public healthcare systems of wealthy countries abroad.

In addition to being unfair, high drug prices in the United States also have serious economic and health consequences for patients in need of treatment. High prices cause Americans to divert too much of their scarce resources to pharmaceutical treatments and away from other productive uses. High prices are also a reason many patients skip doses of their medications, take less than the recommended doses, or abandon treatment altogether. The consequences of these behaviors can be severe. For example, patients may develop acute conditions that result in poor clinical outcomes or that require drastic and expensive medical interventions.

In most markets, the largest buyers pay the lowest prices, but this has not been true for prescription drugs. The Federal Government is the largest payer for prescription drugs in the world, but it pays more than many smaller buyers, including other developed nations. When the Federal Government purchases a drug covered by Medicare—the cost of which is shared by American seniors who take the drug and American taxpayers—it should insist on, at a minimum, the lowest price at which the manufacturer sells that drug to any other developed nation.

SEC. 2. *Policy*. (a) It is the policy of the United States that the Medicare program should not pay more for costly Part B or Part D prescription drugs or biological products than the most-favored-nation price.

(b) The ''most-favored-nation price'' shall mean the lowest price, after adjusting for volume and differences in national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member country of the Organisation for Economic Cooperation and Development (OECD) that has a comparable per-capita gross domestic product.

SEC. 3. *Payment Model on the Most-Favored-Nation Price in Medicare Part B*. To the extent consistent with law, the Secretary of Health and Human Services shall immediately take appropriate steps to implement his rulemaking plan to test a payment model pursuant to which Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price. The model would test whether, for patients who require pharmaceutical treatment, paying no more than the most-favored-nation price would mitigate poor clinical outcomes and increased expenditures associated with high drug costs.

SEC. 4. *Payment Model on the Most-Favored-Nation Price in Medicare Part D*. To the extent consistent with law, the Secretary shall take appropriate steps to develop and implement a rulemaking plan, selecting for testing, consistent with section 1315a(b)(2)(A) of title 42, United States Code, a payment model pursuant to which Medicare would pay, for Part D prescription drugs or biological products where insufficient competition exists and seniors are faced with prices above those in OECD member countries that have a comparable per-capita gross domestic product to the United States, after adjusting for volume and differences in national gross domestic product, no more than the most-favored-nation price, to the extent feasible. The model should test whether, for patients who require pharmaceutical treatment, paying no more than the most-favored-nation price would mitigate poor clinical outcomes and increased expenditures associated with high drug costs.

SEC. 5. *Revocation of Executive Order*. The Executive Order of July 24, 2020 (Lowering Drug Prices by Putting America First) [Ex. Ord. No. 13947, formerly set out above], is revoked.

SEC. 6. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395v. Agreements with States

(a) Duty of Secretary; enrollment of eligible individuals

The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

(b) Coverage of groups to which applicable

An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under subchapter I or subchapter XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under subchapters I, X, XIV, and XVI, and part A of subchapter IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under subchapter II or who is entitled to receive an annuity under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]. Effective January 1, 1974, and subject to section 1396a(f) of this title, the Secretary shall, at the request of any State not eligible to participate in the State plan program established under subchapter XVI, continue in effect the agreement entered into under this section with such State subject to such modifications as the Secretary may by regulations provide to take account of the termination of any plans of such State approved under subchapters I, X, XIV, and XVI and the establishment of the supplemental security income program under subchapter XVI.

(c) Eligible individuals

For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1395*o* of this title) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) Monthly premiums; coverage periods

In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1395r of this title (without any increase under subsection (b) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under subchapter II or to an annuity or pension under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.].

(e) Subsection (d)(3) terminations deemed resulting in section 1395p enrollment

Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1395p of this title in the initial general enrollment period provided by section 1395p(c) of this title. The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.

(f) "Carrier" as including State agency; provisions facilitating deductions, coinsurance, etc., and leading to economy and efficiency of operation

With respect to eligible individuals receiving money payments under the plan of a State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or eligible to receive medical assistance under the plan of such State approved under subchapter XIX, if the agreement entered into under this section so provides, the term ''carrier'' as defined in section 1395u(f)[1] of this title also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under subchapter I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under subchapters I, X, XIV, and XVI, and part A of subchapter IV, and individuals eligible to receive medical assistance under the plan of the State approved under subchapter XIX.

(g) Subsection (b) exclusions from coverage groups

(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection.

[1] See References in Text note below.

(h) Modifications respecting subsection (b) coverage groups

(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under subchapter XIX, or (B) qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title).

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under subchapter XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d)(2)(C) shall be applied (except in the case of qualified medicare beneficiaries, as defined in section 1396d(p)(1) of this title) by substituting ''second month following the first month'' for ''first month''.

(3) In this subsection, the term ''qualified medicare beneficiary'' also includes an individual described in section 1396a(a)(10)(E)(iii) of this title.

(i) Enrollment of qualified medicare beneficiaries

For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1395i–2(g) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1843, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 312; amended Pub. L. 89–384, § 4(a), (b), Apr. 8, 1966, 80 Stat. 105; Pub. L. 90–248, title II, §§ 222(a), (b), (e), 241(e), Jan. 2, 1968, 81 Stat. 900, 901, 917; Pub. L. 93–233, § 18(*l*), Dec. 31, 1973, 87 Stat. 970; Pub. L. 93–445, title III, § 308, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 96–499, title IX, §§ 945(e), 947(a), (c), Dec. 5, 1980, 94 Stat. 2642, 2643; Pub. L. 98–21, title VI, § 606(a)(3)(E), Apr. 20, 1983, 97 Stat. 171; Pub. L. 98–369, div. B, title III, § 2354(b)(15), July 18, 1984, 98 Stat. 1101; Pub. L. 100–360, title III, § 301(e)(1), July 1, 1988, 102 Stat. 749; Pub. L. 100–485, title VI, § 608(d)(14)(H), Oct. 13, 1988, 102 Stat. 2416; Pub. L. 101–239, title VI, § 6013(b), Dec. 19, 1989, 103 Stat. 2164; Pub. L. 101–508, title IV, § 4501(d), Nov. 5, 1990, 104 Stat. 1388–165.)

Editorial Notes

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (d)(3)(B), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, § 101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§ 231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395u(f) of this title, referred to in subsec. (f), was repealed by Pub. L. 108–173, title IX, § 911(c)(5), Dec. 8, 2003, 117 Stat. 2384.

AMENDMENTS

1990—Subsec. (h)(3). Pub. L. 101–508 added par. (3).

1989—Subsec. (i). Pub. L. 101–239 added subsec. (i).

1988—Subsecs. (a), (g)(1). Pub. L. 100–360, § 301(e)(1)(A), formerly § 301(e)(1), as redesignated by Pub. L. 100–485, § 608(d)(14)(H)(i), inserted ''or after 1988'' after ''during 1981''.

Subsec. (h)(1). Pub. L. 100–360, § 301(e)(1)(A), formerly § 301(e)(1), as redesignated by Pub. L. 100–485, § 608(d)(14)(H)(i), inserted ''or after 1988'' after ''during 1981''.

Pub. L. 100–360, § 301(e)(1)(B), as added by Pub. L. 100–485, § 608(d)(14)(H)(ii), inserted cl. (A) designation after ''include'' and added cl. (B).

Subsec. (h)(2). Pub. L. 100–360, § 301(e)(1)(C), as added by Pub. L. 100–485, § 608(d)(14)(H)(ii), inserted ''(except in the case of qualified medicare beneficiaries, as defined in section 1396d(p)(1) of this title)'' after ''shall be applied''.

1984—Subsec. (d)(3)(B). Pub. L. 98–369 substituted ''1974'' for ''1937''.

1983—Subsec. (d)(1). Pub. L. 98–21 substituted ''without any increase under subsection (b) thereof'' for ''without any increase under subsection (c) thereof''.

1980—Subsec. (a). Pub. L. 96–499, § 945(e), inserted ''or during 1981,'' after ''January 1, 1970,''.

Subsec. (e). Pub. L. 96–499, § 947(a), inserted provision that the coverage period under this part of any individual who filed notice that he no longer wished to participate in the insurance program established by this part was to terminate at the close of the month in which the notice was filed.

Subsec. (g)(1). Pub. L. 96–499, § 945(e), inserted ''or during 1981,'' after ''January 1, 1970,''.

Subsec. (g)(2)(C). Pub. L. 96–499, § 947(c)(3), struck out cl. (C) which authorized individuals facing exclusion from the applicable coverage group to terminate their enrollment under this part by the filing of a notice indicating he no longer wished to participate in the insurance program established by this part.

Subsec. (h)(1). Pub. L. 96–499, § 945(e), inserted ''or during 1981,'' after ''January 1, 1970,''.

1974—Subsec. (b). Pub. L. 93–445 substituted ''under the Railroad Retirement Act of 1974'' for ''or pension under the Railroad Retirement Act of 1937''.

1973—Subsec. (b). Pub. L. 93–233 provided for continuation of State agreements for coverage of certain individuals in connection with establishment of supplemental security income program.

1968—Pub. L. 90–248, § 222(b)(4), inserted ''(or are eligible for medical assistance)'' in section catchline.

Subsec. (a). Pub. L. 90–248, § 222(e)(1), substituted ''1970'' for ''1968''.

Subsec. (b)(2). Pub. L. 90–248, § 241(e)(1), struck out ''IV,'' after ''I,'' and inserted '', and part A of subchapter IV'' after ''XVI''.

Subsec. (c). Pub. L. 90–248, § 222(e)(2), struck out ''and before January 1, 1968'' after ''such date'' and ''before January 1968'' after ''thereafter'' just before the period.

Subsec. (d)(2)(D). Pub. L. 90–248, § 222(e)(3), struck out ''(not later than January 1, 1968)'' after ''such date''.

Subsec. (d)(3)(A). Pub. L. 90–248, § 222(b)(1), substituted ''ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance'' for ''ineligible for money payments of a kind specified in the agreement''.

Subsec. (f). Pub. L. 90–248, § 222(b)(2), inserted ''or eligible to receive medical assistance under the plan of such State approved under subchapter XIX'' and '', and individuals eligible to receive medical assistance under the plan of the State approved under subchapter XIX'' after ''or part A of subchapter IV'' and '', and part A of subchapter IV'', respectively.

Pub. L. 90–248, § 241(e)(2), struck out ''IV,'' before ''X,'' in two places, and inserted ''or part A of subchapter IV,'' after ''XVI,'' first place it appears in first sentence and '', and part A of subchapter IV'' after ''XVI'' in second sentence.

Subsec. (g)(1). Pub. L. 90–248, § 222(b)(3), substituted ''1970'' for ''1968''.

Subsec. (h). Pub. L. 90–248, § 222(a), added subsec. (h).

1966—Subsec. (b). Pub. L. 89–384, § 4(a), inserted reference to subsec. (g) in exclusionary provision.

Subsec. (g). Pub. L. 89–384, § 4(b), added subsec. (g).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date, see section 4501(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 effective Jan. 1, 1990, see section 6013(c) of Pub. L. 101–239, set out as a note under section 1395i–2 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title III, § 301(e)(3), July 1, 1988, 102 Stat. 750, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1989, and the amendments made by paragraph (2) [amending section 1396a of this title] shall take effect on July 1, 1989.''

EFFECTIVE DATE OF 1984 AMENDMENT

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

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, § 947(d), Dec. 5, 1980, 94 Stat. 2643, provided that: ''The amendments made by this section [amending this section and section 1395q of this title] apply to notices filed after the third calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980].''

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective Jan. 1, 1974, see Pub. L. 93–233, § 18(z–3)(1), Dec. 31, 1973, 87 Stat. 974.

TERMINATION PERIOD FOR CERTAIN INDIVIDUALS COVERED PURSUANT TO STATE AGREEMENTS

Pub. L. 96–499, title IX, § 947(e), Dec. 5, 1980, 94 Stat. 2643, provided that: ''The coverage period under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] of an individual whose coverage period attributable to a State agreement under section 1843 of such Act [42 U.S.C. 1395v] is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980] that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 [42 U.S.C. 1395q] without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act.''

DISTRICT OF COLUMBIA; AGREEMENT OF COMMISSIONER WITH SECRETARY FOR SUPPLEMENTARY MEDICAL INSURANCE

Pub. L. 90–227, § 2, Dec. 27, 1967, 81 Stat. 745, provided that: ''The Commissioner [now Mayor of District of Columbia] may enter into an agreement (and any modifications of such agreement) with the Secretary under section 1843 of the Social Security Act [42 U.S.C. 1395v] pursuant to which (1) eligible individuals (as defined in section 1836 of the Social Security Act) [42 U.S.C. 1395*o*] who are eligible to receive medical assistance under the District of Columbia's plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] will be enrolled in the supplementary medical insurance program established under part B of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and (2) provisions will be made for payment of the monthly premiums of such individuals for such program.''

§ 1395w. Appropriations to cover Government contributions and contingency reserve

(a) In general

There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1395r(a)(1) of this title for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1395r(a)(3) of this title, to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1395r(a)(4) of this title for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1395r(a)(3) of this title, to

(ii) the dollar amount of the premium per enrollee for such month; minus

(C) the aggregate amount of additional premium payments attributable to the application of section 1395r(i) of this title; plus

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited; plus

(3) a Government contribution equal to the amount of payment incentives payable under sections 1395w–4(*o*) and 1395w–23(*l*)(3) of this title; plus

(4) a Government contribution equal to the estimated aggregate reduction in premiums payable under part B that results from establishing the premium at 15 percent of the actuarial rate (as would be determined in accordance with section 1395r(a)(1) of this title if the reference to ''one-half'' in such section were a reference to ''100 percent'') under section 1395r(j) of this title instead of 25 percent of such rate (as so determined) for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1395*o*(b) of this title.

In applying paragraph (1), the amounts transferred under subsection (d)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1). In applying paragraph (1), the amounts transferred under subsection (e)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1). The Government contribution under paragraph (4) shall be treated as premiums payable and deposited for purposes of subparagraphs (A) and (B) of paragraph (1).

(b) Contingency reserve

In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

(c) Election under section 1395w–24

The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of subsection (a)(1) without regard to any premium reduction resulting from an election under section 1395w–24(f)(1)(E) of this title or any credits provided under section 1395w–24(b)(1)(C)(iv)[1] of this title and without regard to any premium adjustment effected under sections 1395r(h) and 1395w–29(f)[1] of this title and without regard to any premium adjustment under section 1395r(i) of this title.

(d) Transfer of certain General Fund amounts for 2016

(1) For 2016, there shall be transferred from the General Fund to the Trust Fund an amount, as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services, equal to the reduction in aggregate premiums payable under this part for a month in such year (excluding any changes in amounts collected under section 1395r(i) of this title) that is attributable to the application of section 1395r(a)(5)(A) of this title with respect to—

(A) enrollees age 65 and over; and

(B) enrollees under age 65.

Such amounts shall be transferred from time to time as appropriate.

(2) Premium increases affected under section 1395r(a)(6) of this title shall not be taken into account in applying subsection (a).

(3) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the additional premiums payable as a result of the application of section 1395r(a)(6) of this title, excluding the aggregate payments attributable to the application of section 1395r(i)(3)(A)(ii)(II) of this title.

(e) Transfer of certain General Fund amounts for 2021

(1) For 2021, there shall be transferred from the General Fund to the Trust Fund an amount, as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services, equal to the reduction in aggregate premiums payable under this part for a month in such year (excluding any changes in amounts collected under section 1395r(i) of this title) that are attributable to the application of section 1395r(a)(7) of this title with respect to—

(A) enrollees age 65 and over; and

(B) enrollees under age 65.

Such amounts shall be transferred from time to time as appropriate.

(2) Premium increases affected under section 1395r(a)(6) of this title shall not be taken into account in applying subsection (a).

(3) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the additional premiums payable as a result of the application of section 1395r(a)(6) of this title, excluding the aggregate payments attributable to the application of section 1395r(i)(3)(A)(ii)(II) of this title.

(f) Transfer of certain General Fund amounts for COVID–19 public health emergency period

(1) There shall be transferred from the General Fund of the Treasury to the Trust Fund an amount, as estimated by the Chief Actuary of

[1] See References in Text note below.

the Centers for Medicare & Medicaid Services, equal to amounts paid in advance for items and services under this part during the period beginning on the first day of the emergency period described in section 1320b–5(g)(1)(B) of this title and ending on October 1, 2020.

(2) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the sum of—

(A) the amounts by which claims have offset (in whole or in part) the amount of such payments described in paragraph (1); and

(B) the amount of such payments that have been repaid (in whole or in part).

(3) Amounts described in paragraphs (1) and (2) shall be transferred from time to time as appropriate.

(Aug. 14, 1935, ch. 531, title XVIII, § 1844, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 313; amended Pub. L. 90–248, title I, § 167, Jan. 2, 1968, 81 Stat. 874; Pub. L. 92–603, title II, § 203(e), Oct. 30, 1972, 86 Stat. 1377; Pub. L. 97–248, title I, § 124(c), Sept. 3, 1982, 96 Stat. 364; Pub. L. 98–21, title VI, § 606(a)(3)(F), (G), Apr. 20, 1983, 97 Stat. 171; Pub. L. 98–369, div. B, title III, § 2354(b)(16), July 18, 1984, 98 Stat. 1101; Pub. L. 100–360, title II, § 211(c)(2), July 1, 1988, 102 Stat. 738; Pub. L. 101–234, title II, § 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 105–33, title IV, § 4571(b)(2), Aug. 5, 1997, 111 Stat. 464; Pub. L. 106–554, § 1(a)(6) [title VI, § 606(a)(2)(D)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558; Pub. L. 108–173, title II, §§ 222(*l*)(2)(C), 241(b)(2)(B), title VIII, § 811(b)(2), Dec. 8, 2003, 117 Stat. 2206, 2221, 2368; Pub. L. 111–5, div. B, title IV, § 4103(a)(2), Feb. 17, 2009, 123 Stat. 487; Pub. L. 114–74, title VI, § 601(b), Nov. 2, 2015, 129 Stat. 595; Pub. L. 116–159, div. C, title IV, § 2401(b), (c), Oct. 1, 2020, 134 Stat. 732, 733; Pub. L. 116–260, div. CC, title IV, § 402(e), Dec. 27, 2020, 134 Stat. 3001.)

Editorial Notes

References in Text

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (c), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, § 3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, § 1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 1395w–29 of this title, referred to in subsec. (c), was repealed by Pub. L. 111–152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046.

Amendments

2020—Subsec. (a). Pub. L. 116–260, § 402(e)(3), inserted at end of concluding provisions ''The Government contribution under paragraph (4) shall be treated as premiums payable and deposited for purposes of subparagraphs (A) and (B) of paragraph (1).''

Pub. L. 116–159, § 2401(b)(1), inserted at end of concluding provisions ''In applying paragraph (1), the amounts transferred under subsection (e)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1).''

Subsec. (a)(4). Pub. L. 116–260, § 402(e), added par. (4).

Subsec. (e). Pub. L. 116–159, § 2401(b)(2), added subsec. (e).

Subsec. (f). Pub. L. 116–159, § 2401(c), added subsec. (f).

2015—Subsec. (a). Pub. L. 114–74, § 601(b)(1), inserted concluding provisions.

Subsec. (d). Pub. L. 114–74, § 601(b)(2), added subsec. (d).

2009—Subsec. (a)(2), (3). Pub. L. 111–5 in par. (2) substituted ''; plus'' for period at end and added par. (3).

2003—Subsec. (a)(1)(B)(ii). Pub. L. 108–173, § 811(b)(2)(A)(i), substituted ''minus'' for ''plus''.

Subsec. (a)(1)(C). Pub. L. 108–173, § 811(b)(2)(A)(ii), added subpar. (C).

Subsec. (c). Pub. L. 108–173, § 811(b)(2)(B), inserted ''and without regard to any premium adjustment under section 1395r(i) of this title'' before period at end.

Pub. L. 108–173, § 241(b)(2)(B), inserted ''and without regard to any premium adjustment effected under sections 1395r(h) and 1395w–29(f) of this title'' before period at end.

Pub. L. 108–173, § 222(*l*)(2)(C), inserted ''or any credits provided under section 1395w–24(b)(1)(C)(iv) of this title'' after ''section 1395w–24(f)(1)(E) of this title''.

2000—Subsec. (c). Pub. L. 106–554 added subsec. (c).

1997—Subsec. (a)(1)(A)(i), (B)(i). Pub. L. 105–33 substituted ''section 1395r(a)(3) of this title'' for ''section 1395r(a)(3) or 1395r(e) of this title, as the case may be''.

1989—Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, § 211(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a). Pub. L. 100–360 inserted at end ''In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1395r(g) of this title or section 59B of the Internal Revenue Code of 1986.''

1984—Subsec. (a)(1)(B)(ii). Pub. L. 98–369 substituted ''; plus'' for a period.

1983—Subsec. (a)(1)(A)(i). Pub. L. 98–21, § 606(a)(3)(F), substituted ''section 1395r(a)(1)'' for ''section 1395r(c)(1)'' and ''section 1395r(a)(3) or 1395r(e)'' for ''section 1395r(c)(3) or 1395r(g)''.

Subsec. (a)(1)(B)(i). Pub. L. 98–21, § 606(a)(3)(G), substituted ''1395r(a)(4)'' for ''1395r(c)(4)'' and ''1395r(a)(3) or 1395r(e)'' for ''1395r(c)(3) or 1395r(g)''.

1982—Subsec. (a)(1)(A)(i), (B)(i). Pub. L. 97–248 substituted ''section 1395r(c)(3) or 1395r(g) of this title, as the case may be'' for ''section 1395r(c)(3) of this title''.

1972—Subsec. (a)(1). Pub. L. 92–603 designated existing provisions as subpar. (A), substituted provisions relating to Government contributions equal to aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in Trust Fund, and multiplied by specified ratio, for provisions relating to Government contributions equal to aggregate premiums payable under this part and deposited in Trust Fund, and added subpar. (B).

1968—Subsec. (a). Pub. L. 90–248, § 167(a), designated existing provisions as par. (1), inserted provision for deposit of Government contribution in Trust Fund, and added par. (2).

Subsec. (b). Pub. L. 90–248, § 167(b), substituted ''1969'' for ''1967''.

Statutory Notes and Related Subsidiaries

Effective Date of 2003 Amendment

Amendment by section 222(*l*)(2)(C) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Effective Date of 2000 Amendment

Amendment by Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, § 606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Effective Date of 1989 Amendment

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–360 applicable, except as otherwise specified in such amendment, to monthly premiums for months beginning with January 1989, see section 211(d) of Pub. L. 100–360, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

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

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the amount of Government contributions under subsec. (a)(1) of this section shall be computed with the actuarially adequate rate which would have been in effect but for the amendments made by this section and using the amount of the premium in effect for June 1983, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 203(e), Oct. 30, 1972, 86 Stat. 1377, provided that the amendment made by that section is effective with respect to enrollee premiums payable for months after June 1973.

CONSTRUCTION OF 2015 AMENDMENT; CONDITIONAL APPLICATION TO 2017

For provisions relating to construction and application of amendment by Pub. L. 114–74, see sections 601(d) and 601(e) of Pub. L. 114–74, set out as notes under section 1395r of this title.

§ 1395w–1. Repealed. Pub. L. 105–33, title IV, § 4022(b)(2)(A), Aug. 5, 1997, 111 Stat. 354

Section, act Aug. 14, 1935, ch. 531, title XVIII, § 1845, as added and amended Apr. 7, 1986, Pub. L. 99–272, title IX, § 9305, 100 Stat. 190; Oct. 21, 1986, Pub. L. 99–509, title IX, §§ 9331(e), 9344(a)(1), 100 Stat. 2021, 2042; Dec. 22, 1987, Pub. L. 100–203, title IV, §§ 4045(b), 4083(a)(1), (c)(1), 4085(a), (i)(8), 101 Stat. 1330–87, 1330–129, 1330–130, 1330–132; July 1, 1988, Pub. L. 100–360, title IV, § 411(i)(4)(A), 102 Stat. 788; Nov. 10, 1988, Pub. L. 100–647, title VIII, § 8425(a), 102 Stat. 3803; Nov. 5, 1990, Pub. L. 101–508, title IV, §§ 4002(g)(3), 4118(j)(1), 104 Stat. 1388–37, 1388–70; Oct. 31, 1994, Pub. L. 103–432, title I, § 126(g)(8), 108 Stat. 4416, related to Physician Payment Review Commission.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF REPEAL

Repeal effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33 set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

§ 1395w–2. Intermediate sanctions for providers or suppliers of clinical diagnostic laboratory tests

(a) If the Secretary determines that any provider or clinical laboratory approved for participation under this subchapter no longer substantially meets the conditions of participation or for coverage specified under this subchapter with respect to the provision of clinical diagnostic laboratory tests under this part, the Secretary may (for a period not to exceed one year) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory.

(b)(1) The Secretary shall develop and implement—

(A) a range of intermediate sanctions to apply to providers or clinical laboratories under the conditions described in subsection (a), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) directed plans of correction,

(ii) civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance,

(iii) payment for the costs of onsite monitoring by an agency responsible for conducting surveys, and

(iv) suspension of all or part of the payments to which a provider or clinical laboratory would otherwise be entitled under this subchapter with respect to clinical diagnostic laboratory tests furnished on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a).

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

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law.

(3) The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions developed under paragraph (1) is to be applied, the amounts of any penalties, and the severity of each of these penalties. Such procedures shall be designed so as to minimize the time between identification of violations and imposition of these sanctions and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(Aug. 14, 1935, ch. 531, title XVIII, § 1846, as added Pub. L. 100–203, title IV, § 4064(d)(1), Dec. 22, 1987, 101 Stat. 1330–111; amended Pub. L. 100–360, title II, § 203(e)(4), title IV, § 411(g)(3)(G), July 1, 1988, 102 Stat. 725, 784; Pub. L. 100–485, title VI, § 608(d)(22)(C), Oct. 13, 1988, 102 Stat. 2421; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–508, title IV, § 4154(e)(2), Nov. 5, 1990, 104 Stat. 1388–86.)

Editorial Notes

AMENDMENTS

1990—Pub. L. 101–508 substituted ''providers or suppliers of'' for ''providers of'' in section catchline.

1989—Pub. L. 101–234 repealed Pub. L. 100–360, § 203(e)(4), and provided that the provisions of law

amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Pub. L. 100–360, §203(e)(4)(A), inserted ''and for qualified home intravenous drug therapy providers'' at end of section catchline.

Subsec. (a). Pub. L. 100–360, §411(g)(3)(G)(i)(I), as amended by Pub. L. 100–485, substituted ''approved'' for ''certified''.

Pub. L. 100–360, §411(g)(3)(G)(i)(II), inserted ''or for coverage'' after ''conditions of participation''.

Pub. L. 100–360, §411(g)(3)(G)(i)(III), which directed amendment of subsec. (a) by substituting ''terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory'' for ''cancelling immediately the certification of the provider or clinical laboratory'', was executed by making the substitution for ''canceling immediately the certification of the provider or clinical laboratory'' to reflect the probable intent of Congress.

Pub. L. 100–360, §203(e)(4)(B), inserted ''or that a qualified home intravenous drug therapy provider that is certified for participation under this subchapter no longer substantially meets the requirements of section 1395x(jj)(3) of this title'' after ''under this part''.

Subsec. (b)(1)(A). Pub. L. 100–360, §411(g)(3)(G)(ii), struck out ''certified'' before ''clinical laboratories''.

Subsec. (b)(2)(A). Pub. L. 100–360, §411(g)(3)(G)(iv), inserted at end ''The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (b)(2)(A)(ii). Pub. L. 100–360, §411(g)(3)(G)(iii), substituted ''civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance'' for ''civil fines and penalties''.

Subsec. (b)(2)(A)(iii). Pub. L. 100–360, §411(g)(3)(G)(v), struck out ''certification'' before ''surveys''.

Subsec. (b)(2)(A)(iv). Pub. L. 100–360, §411(g)(3)(G)(ii), (vi), struck out ''certified'' before ''clinical laboratory'' and substituted ''furnished on or after the date on'' for ''provided on or after the date in''.

Pub. L. 100–360, §203(e)(4)(C), inserted ''or home intravenous drug therapy services'' after ''clinical diagnostic laboratory tests''.

Subsec. (b)(3). Pub. L. 100–360, §411(g)(3)(G)(vii), substituted ''any penalties'' for ''any fines'' and ''severe penalties'' for ''severe fines''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4154(e)(5) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 203(e)(4) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(g)(3)(G) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100–203, title IV, §4064(d)(2), Dec. 22, 1987, 101 Stat. 1330–111, provided that: ''The amendment made by paragraph (1) [enacting this section] shall become effective on January 1, 1990.''

§ 1395w–3. Competitive acquisition of certain items and services

(a) Establishment of competitive acquisition programs

(1) Implementation of programs

(A) In general

The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) Phased-in implementation

The programs—

(i) shall be phased in among competitive acquisition areas in a manner consistent with subparagraph (D) so that the competition under the programs occurs in—

(I) 10 of the largest metropolitan statistical areas in 2007;

(II) an additional 91 of the largest metropolitan statistical areas in 2011; and

(III) additional areas after 2011 (or, in the case of national mail order for items and services, after 2010); and

(ii) may be phased in first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.

(C) Waiver of certain provisions

In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Changes in competitive acquisition programs

(i) Round 1 of competitive acquisition program

Notwithstanding subparagraph (B)(i)(I) and in implementing the first round of the competitive acquisition programs under this section—

(I) the contracts awarded under this section before July 15, 2008, are terminated, no payment shall be made under this subchapter on or after July 15, 2008, based on such a contract, and, to the extent that any damages may be applicable as a result of the termination of such contracts, such damages shall be payable

from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title;

(II) the Secretary shall conduct the competition for such round in a manner so that it occurs in 2009 with respect to the same items and services and the same areas, except as provided in subclauses (III) and (IV);

(III) the Secretary shall exclude Puerto Rico so that such round of competition covers 9, instead of 10, of the largest metropolitan statistical areas; and

(IV) there shall be excluded negative pressure wound therapy items and services.

Nothing in subclause (I) shall be construed to provide an independent cause of action or right to administrative or judicial review with regard to the termination provided under such subclause.

(ii) Round 2 of competitive acquisition program

In implementing the second round of the competitive acquisition programs under this section described in subparagraph (B)(i)(II)—

(I) the metropolitan statistical areas to be included shall be those metropolitan statistical areas selected by the Secretary for such round as of June 1, 2008;

(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and

(III) the Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes.

(iii) Exclusion of certain areas in subsequent rounds of competitive acquisition programs

In implementing subsequent rounds of the competitive acquisition programs under this section, including under subparagraph (B)(i)(III), for competitions occurring before 2015, the Secretary shall exempt from the competitive acquisition program (other than national mail order) the following:

(I) Rural areas.

(II) Metropolitan statistical areas not selected under round 1 or round 2 with a population of less than 250,000.

(III) Areas with a low population density within a metropolitan statistical area that is otherwise selected, as determined for purposes of paragraph (3)(A).

(E) Verification by OIG

The Inspector General of the Department of Health and Human Services shall, through post-award audit, survey, or otherwise, assess the process used by the Centers for Medicare & Medicaid Services to conduct competitive bidding and subsequent pricing determinations under this section that are the basis for pivotal bid amounts and single payment amounts for items and services in competitive bidding areas under rounds 1 and 2 of the competitive acquisition programs under this section and may continue to verify such calculations for subsequent rounds of such programs.

(F) Supplier feedback on missing financial documentation

(i) In general

In the case of a bid where one or more covered documents in connection with such bid have been submitted not later than the covered document review date specified in clause (ii), the Secretary—

(I) shall provide, by not later than 45 days (in the case of the first round of the competitive acquisition programs as described in subparagraph (B)(i)(I)) or 90 days (in the case of a subsequent round of such programs) after the covered document review date, for notice to the bidder of all such documents that are missing as of the covered document review date; and

(II) may not reject the bid on the basis that any covered document is missing or has not been submitted on a timely basis, if all such missing documents identified in the notice provided to the bidder under subclause (I) are submitted to the Secretary not later than 10 business days after the date of such notice.

(ii) Covered document review date

The covered document review date specified in this clause with respect to a competitive acquisition program is the later of—

(I) the date that is 30 days before the final date specified by the Secretary for submission of bids under such program; or

(II) the date that is 30 days after the first date specified by the Secretary for submission of bids under such program.

(iii) Limitations of process

The process provided under this subparagraph—

(I) applies only to the timely submission of covered documents;

(II) does not apply to any determination as to the accuracy or completeness of covered documents submitted or whether such documents meet applicable requirements;

(III) shall not prevent the Secretary from rejecting a bid based on any basis not described in clause (i)(II); and

(IV) shall not be construed as permitting a bidder to change bidding amounts or to make other changes in a bid submission.

(iv) Covered document defined

In this subparagraph, the term ''covered document'' means a financial, tax, or other document required to be submitted by a bidder as part of an original bid submission under a competitive acquisition

program in order to meet required financial standards. Such term does not include other documents, such as the bid itself or accreditation documentation.

(G) Requiring bid bonds for bidding entities

With respect to rounds of competitions beginning under this subsection for contracts beginning not earlier than January 1, 2017, and not later than January 1, 2019, an entity may not submit a bid for a competitive acquisition area unless, as of the deadline for bid submission, the entity has obtained (and provided the Secretary with proof of having obtained) a bid surety bond (in this paragraph referred to as a ''bid bond'') in a form specified by the Secretary consistent with subparagraph (H) and in an amount that is not less than $50,000 and not more than $100,000 for each competitive acquisition area in which the entity submits the bid.

(H) Treatment of bid bonds submitted

(i) For bidders that submit bids at or below the median and are offered but do not accept the contract

In the case of a bidding entity that is offered a contract for any product category for a competitive acquisition area, if—

(I) the entity's composite bid for such product category and area was at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amounts for such product category and area; and

(II) the entity does not accept the contract offered for such product category and area,

the bid bond submitted by such entity for such area shall be forfeited by the entity and the Secretary shall collect on it.

(ii) Treatment of other bidders

In the case of a bidding entity for any product category for a competitive acquisition area, if the entity does not meet the bid forfeiture conditions in subclauses (I) and (II) of clause (i) for any product category for such area, the bid bond submitted by such entity for such area shall be returned within 90 days of the public announcement of the contract suppliers for such area.

(2) Items and services described

The items and services referred to in paragraph (1) are the following:

(A) Durable medical equipment and medical supplies

Covered items (as defined in section 1395m(a)(13) of this title) for which payment would otherwise be made under section 1395m(a) of this title, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher, complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes) (and related accessories when furnished in connection with such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs), and excluding drugs and biologicals described in section 1395u(*o*)(1)(D) of this title.

(B) Other equipment and supplies

Items and services described in section 1395u(s)(2)(D) of this title, other than parenteral nutrients, equipment, and supplies.

(C) Off-the-shelf orthotics

Orthotics described in section 1395x(s)(9) of this title for which payment would otherwise be made under section 1395m(h) of this title which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

(3) Exception authority

In carrying out the programs under this section, the Secretary may exempt—

(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(4) Special rule for certain rented items of durable medical equipment and oxygen

In the case of a covered item for which payment is made on a rental basis under section 1395m(a) of this title and in the case of payment for oxygen under section 1395m(a)(5) of this title, the Secretary shall establish a process by which rental agreements for the covered items and supply arrangements with oxygen suppliers entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1395m(a) of this title.

(5) Physician authorization

(A) In general

With respect to items or services included within a particular HCPCS code, the Secretary may establish a process for certain items and services under which a physician may prescribe a particular brand or mode of delivery of an item or service within such code if the physician determines that use of the particular item or service would avoid an adverse medical outcome on the individual, as determined by the Secretary.

(B) No effect on payment amount

A prescription under subparagraph (A) shall not affect the amount of payment oth-

erwise applicable for the item or service under the code involved.

(6) Application

For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1395m(a) of this title, section 1395m(h) of this title, or section 1395u(s) of this title, as appropriate.

(7) Exemption from competitive acquisition

The programs under this section shall not apply to the following:

(A) Certain off-the-shelf orthotics

Items and services described in paragraph (2)(C) if furnished—

(i) by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or

(ii) by a hospital to the hospital's own patients during an admission or on the date of discharge.

(B) Certain durable medical equipment

Those items and services described in paragraph (2)(A)—

(i) that are furnished by a hospital to the hospital's own patients during an admission or on the date of discharge; and

(ii) to which such programs would not apply, as specified by the Secretary, if furnished by a physician to the physician's own patients as part of the physician's professional service.

(b) Program requirements

(1) In general

The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) Conditions for awarding contract

(A) In general

The Secretary may not award a contract to any entity under the competition conducted in an[1] competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets applicable quality standards specified by the Secretary under section 1395m(a)(20) of this title.

(ii) The entity meets applicable financial standards specified by the Secretary, taking into account the needs of small providers.

(iii) The total amounts to be paid to contractors in a competitive acquisition area are expected to be less than the total amounts that would otherwise be paid.

(iv) Access of individuals to a choice of multiple suppliers in the area is maintained.

(v) The entity meets applicable State licensure requirements.

(B) Timely implementation of program

Any delay in the implementation of quality standards under section 1395m(a)(20) of this title or delay in the receipt of advice from the program oversight committee established under subsection (c) shall not delay the implementation of the competitive acquisition program under this section.

(3) Contents of contract

(A) In general

A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) Term of contracts

The Secretary shall recompete contracts under this section not less often than once every 3 years.

(C) Disclosure of subcontractors

(i) Initial disclosure

Not later than 10 days after the date a supplier enters into a contract with the Secretary under this section, such supplier shall disclose to the Secretary, in a form and manner specified by the Secretary, the information on—

(I) each subcontracting relationship that such supplier has in furnishing items and services under the contract; and

(II) whether each such subcontractor meets the requirement of section 1395m(a)(20)(F)(i) of this title, if applicable to such subcontractor.

(ii) Subsequent disclosure

Not later than 10 days after such a supplier subsequently enters into a subcontracting relationship described in clause (i)(II), such supplier shall disclose to the Secretary, in such form and manner, the information described in subclauses (I) and (II) of clause (i).

(4) Limit on number of contractors

(A) In general

The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of individuals for such items or services in the geographic area covered under the contract on a timely basis.

(B) Multiple winners

The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

[1] So in original. Probably should be ''a''.

(5) Payment

(A) In general

Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on bids submitted and accepted under this section for such items and services. Based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area.

(B) Reduced beneficiary cost-sharing

(i) Application of coinsurance

Payment under this section for items and services shall be in an amount equal to 80 percent of the payment basis described in subparagraph (A).

(ii) Application of deductible

Before applying clause (i), the individual shall be required to meet the deductible described in section 1395*l*(b) of this title.

(C) Payment on assignment-related basis

Payment for any item or service furnished by the entity may only be made under this section on an assignment-related basis.

(D) Construction

Nothing in this section shall be construed as precluding the use of an advanced beneficiary notice with respect to a competitively priced item and service.

(6) Participating contractors

(A) In general

Except as provided in subsection (a)(4), payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

(i) the contractor has submitted a bid for such items and services under this section; and

(ii) the Secretary has awarded a contract to the contractor for such items and services under this section.

(B) Bid defined

In this section, the term ''bid'' means an offer to furnish an item or service for a particular price and time period that includes, where appropriate, any services that are attendant to the furnishing of the item or service.

(C) Rules for mergers and acquisitions

In applying subparagraph (A) to a contractor, the contractor shall include a successor entity in the case of a merger or acquisition, if the successor entity assumes such contract along with any liabilities that may have occurred thereunder.

(D) Protection of small suppliers

In developing procedures relating to bids and the awarding of contracts under this section, the Secretary shall take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program under this section.

(7) Consideration in determining categories for bids

The Secretary may consider the clinical efficiency and value of specific items within codes, including whether some items have a greater therapeutic advantage to individuals.

(8) Authority to contract for education, monitoring, outreach, and complaint services

The Secretary may enter into contracts with appropriate entities to address complaints from individuals who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such individuals and monitoring quality of services with respect to the program.

(9) Authority to contract for implementation

The Secretary may contract with appropriate entities to implement the competitive bidding program under this section.

(10) Special rule in case of competition for diabetic testing strips

(A) In general

With respect to the competitive acquisition program for diabetic testing strips conducted after the first round of the competitive acquisition programs, if an entity does not demonstrate to the Secretary that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products, the Secretary shall reject such bid. With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets.

(B) Study of types of testing strip products

Before 2011, the Inspector General of the Department of Health and Human Services shall conduct a study to determine the types of diabetic testing strip products by volume that could be used to make determinations pursuant to subparagraph (A) for the first competition under the competitive acquisition program described in such subparagraph and submit to the Secretary a report on the results of the study. The Inspector General shall also conduct such a study and submit such a report before the Secretary conducts a subsequent competitive acquistion[2] program described in subparagraph (A).

(C) Demonstration of ability to furnish types of diabetic testing strip products

With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, an entity shall attest to the Secretary that the entity has the ability to obtain an

[2] So in original. Probably should be ''acquisition''.

inventory of the types and quantities of diabetic testing strip products that will allow the entity to furnish such products in a manner consistent with its bid and—

(i) demonstrate to the Secretary, through letters of intent with manufacturers, wholesalers, or other suppliers, or other evidence as the Secretary may specify, such ability; or

(ii) demonstrate to the Secretary that it made a good faith attempt to obtain such a letter of intent or such other evidence.

(D) Use of unlisted types in calculation of percentage

With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, in determining under subparagraph (A) whether a bid submitted by an entity under such subparagraph covers 50 percent (or such higher percentage as the Secretary may specify) of all types of diabetic testing strip products, the Secretary may not attribute a percentage to types of diabetic testing strip products that the Secretary does not identify by brand, model, and market share volume.

(E) Adherence to demonstration

(i) In general

In the case of an entity that is furnishing diabetic testing strip products on or after January 1, 2019, under a contract entered into under the competition conducted pursuant to paragraph (1), the Secretary shall establish a process to monitor, on an ongoing basis, the extent to which such entity continues to cover the product types included in the entity's bid.

(ii) Termination

If the Secretary determines that an entity described in clause (i) fails to maintain in inventory, or otherwise maintain ready access to (through requirements, contracts, or otherwise) a type of product included in the entity's bid, the Secretary may terminate such contract unless the Secretary finds that the failure of the entity to maintain inventory of, or ready access to, the product is the result of the discontinuation of the product by the product manufacturer, a market-wide shortage of the product, or the introduction of a newer model or version of the product in the market involved.

(11) Additional special rules in case of competition for diabetic testing strips

(A) In general

With respect to an entity that is furnishing diabetic testing strip products to individuals under a contract entered into under the competitive acquisition program established under this section, the entity shall furnish to each individual a brand of such products that is compatible with the home blood glucose monitor selected by the individual.

(B) Prohibition on influencing and incentivizing

An entity described in subparagraph (A) may not attempt to influence or incentivize an individual to switch the brand of glucose monitor or diabetic testing strip product selected by the individual, including by—

(i) persuading, pressuring, or advising the individual to switch; or

(ii) furnishing information about alternative brands to the individual where the individual has not requested such information.

(C) Provision of information

(i) Standardized information

Not later than January 1, 2019, the Secretary shall develop and make available to entities described in subparagraph (A) standardized information that describes the rights of an individual with respect to such an entity. The information described in the preceding sentence shall include information regarding—

(I) the requirements established under subparagraphs (A) and (B);

(II) the right of the individual to purchase diabetic testing strip products from another mail order supplier of such products or a retail pharmacy if the entity is not able to furnish the brand of such product that is compatible with the home blood glucose monitor selected by the individual; and

(III) the right of the individual to return diabetic testing strip products furnished to the individual by the entity.

(ii) Requirement

With respect to diabetic testing strip products furnished on or after the date on which the Secretary develops the standardized information under clause (i), an entity described in subparagraph (A) may not communicate directly to an individual until the entity has verbally provided the individual with such standardized information.

(D) Order refills

With respect to diabetic testing strip products furnished on or after January 1, 2019, the Secretary shall require an entity furnishing diabetic testing strip products to an individual to contact and receive a request from the individual for such products not more than 14 days prior to dispensing a refill of such products to the individual.

(12) No administrative or judicial review

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

(A) the establishment of payment amounts under paragraph (5);

(B) the awarding of contracts under this section;

(C) the designation of competitive acquisition areas under subsection (a)(1)(A) and the identification of areas under subsection (a)(1)(D)(iii);

(D) the phased-in implementation under subsection (a)(1)(B) and implementation of subsection (a)(1)(D);

(E) the selection of items and services for competitive acquisition under subsection (a)(2);

(F) the bidding structure and number of contractors selected under this section; or

(G) the implementation of the special rule described in paragraph (10).

(c) Program Advisory and Oversight Committee

(1) Establishment

The Secretary shall establish a Program Advisory and Oversight Committee (hereinafter in this section referred to as the ''Committee'').

(2) Membership; terms

The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

(3) Duties

(A) Advice

The Committee shall provide advice to the Secretary with respect to the following functions:

(i) The implementation of the program under this section.

(ii) The establishment of financial standards for purposes of subsection (b)(2)(A)(ii).

(iii) The establishment of requirements for collection of data for the efficient management of the program.

(iv) The development of proposals for efficient interaction among manufacturers, providers of services, suppliers (as defined in section 1395x(d) of this title), and individuals.

(v) The establishment of quality standards under section 1395m(a)(20) of this title.

(B) Additional duties

The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

(4) Inapplicability of FACA

The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

(5) Termination

The Committee shall terminate on December 31, 2011.

(d) Report

Not later than July 1, 2011, the Secretary shall submit to Congress a report on the programs under this section. The report shall include information on savings, reductions in cost-sharing, access to and quality of items and services, and satisfaction of individuals.

(e) Repealed. Pub. L. 110–275, title I, § 145(a)(1), July 15, 2008, 122 Stat. 2547

(f) Competitive acquisition ombudsman

The Secretary shall provide for a competitive acquisition ombudsman within the Centers for Medicare & Medicaid Services in order to respond to complaints and inquiries made by suppliers and individuals relating to the application of the competitive acquisition program under this section. The ombudsman may be within the office of the Medicare Beneficiary Ombudsman appointed under section 1395b–9(c) of this title. The ombudsman shall submit to Congress an annual report on the activities under this subsection, which report shall be coordinated with the report provided under section 1395b–9(c)(2)(C) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1847, as added Pub. L. 105–33, title IV, § 4319(a), Aug. 5, 1997, 111 Stat. 392; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title III, § 302(b)(1), Dec. 8, 2003, 117 Stat. 2224; Pub. L. 110–275, title I, §§ 145(a)(1), 154(a)(1), (b)(2), (3), (c)(2)(A), (B), (d)(1), (3), (4), July 15, 2008, 122 Stat. 2547, 2560, 2565–2568; Pub. L. 111–148, title VI, § 6410(a), Mar. 23, 2010, 124 Stat. 773; Pub. L. 114–10, title V, § 522(a), (b)(1), Apr. 16, 2015, 129 Stat. 176, 177; Pub. L. 114–255, div. A, title V, § 5004(b)(1), Dec. 13, 2016, 130 Stat. 1191; Pub. L. 115–123, div. E, title IV, § 50414(a), (b), Feb. 9, 2018, 132 Stat. 221, 222; Pub. L. 116–94, div. N, title I, § 106(a), Dec. 20, 2019, 133 Stat. 3101.)

Editorial Notes

REFERENCES IN TEXT

The Federal Food, Drug, and Cosmetic Act, referred to in subsec. (a)(2)(A), is act June 25, 1938, ch. 675, 52 Stat. 1040, as amended, which is classified generally to chapter 9 (§ 301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

The Federal Advisory Committee Act, referred to in subsec. (c)(4), is Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, as amended, which is set out in the Appendix to Title 5, Government Organization and Employees.

PRIOR PROVISIONS

A prior section 1395w–3, act Aug. 14, 1935, ch. 531, title XVIII, § 1847, as added July 1, 1988, Pub. L. 100–360, title II, § 202(j), 102 Stat. 719; amended Oct. 13, 1988, Pub. L. 100–485, title VI, § 608(d)(5)(I), 102 Stat. 2414, provided for appointment of Prescription Drug Payment Review Commission by Director of Congressional Office of Technology Assessment, prior to repeal by Pub. L. 101–234, title II, § 201(a), (c), Dec. 13, 1989, 103 Stat. 1981, effective Jan. 1, 1990.

AMENDMENTS

2019—Subsec. (a)(2)(A). Pub. L. 116–94 inserted '', complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes)'' after ''group 3 or higher'' and substituted ''such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs'' for ''such wheelchairs''.

2018—Subsec. (b)(10)(A). Pub. L. 115–123, § 50414(a)(1)(A), substituted ''With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets.'' for ''The volume for such types of products may be determined in accordance with such data (which may be market based data) as the Secretary recognizes.''

Subsec. (b)(10)(C) to (E). Pub. L. 115–123, § 50414(a)(1)(B), added subpars. (C) to (E).

Subsec. (b)(11), (12). Pub. L. 115–123, § 50414(b), added par. (11) and redesignated former par. (11) as (12).

2016—Subsec. (a)(2)(A). Pub. L. 114–255 substituted '', excluding certain'' for ''and excluding certain'' and

inserted before period at end '', and excluding drugs and biologicals described in section 1395u(*o*)(1)(D) of this title''.

2015—Subsec. (a)(1)(G), (H). Pub. L. 114–10, § 522(a), added subpars. (G) and (H).

Subsec. (b)(2)(A)(v). Pub. L. 114–10, § 522(b)(1), added cl. (v).

2010—Subsec. (a)(1)(B)(i)(II). Pub. L. 111–148, § 6410(a)(1), substituted ''91'' for ''70''.

Subsec. (a)(1)(D)(ii)(II), (III). Pub. L. 111–148, § 6410(a)(2), added subcl. (II) and redesignated former subcl. (II) as (III).

2008—Subsec. (a)(1)(B)(i). Pub. L. 110–275, § 154(a)(1)(A)(i), inserted ''consistent with subparagraph (D)'' after ''in a manner'' in introductory provisions.

Subsec. (a)(1)(B)(i)(II). Pub. L. 110–275, § 154(a)(1)(A)(ii), substituted ''an additional 70'' for ''80'' and ''in 2011'' for ''in 2009''.

Subsec. (a)(1)(B)(i)(III). Pub. L. 110–275, § 154(a)(1)(A)(iii), substituted ''after 2011 (or, in the case of national mail order for items and services, after 2010)'' for ''after 2009''.

Subsec. (a)(1)(D) to (F). Pub. L. 110–275, § 154(a)(1)(A)(iv), added subpars. (D) to (F).

Subsec. (a)(2)(A). Pub. L. 110–275, § 154(a)(1)(B), which directed amendment of par. (2)(A) of subsec. (a)(1) by inserting ''and excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher (and related accessories when furnished in connection with such wheelchairs)'' before period at end, was executed by making the insertion in subsec. (a)(2)(A), to reflect the probable intent of Congress.

Subsec. (a)(7). Pub. L. 110–275, § 154(d)(1), added par. (7).

Subsec. (b)(3)(C). Pub. L. 110–275, § 154(b)(2), added subpar. (C).

Subsec. (b)(10). Pub. L. 110–275, § 154(d)(3)(B), added par. (10). Former par. (10) redesignated (11).

Subsec. (b)(11). Pub. L. 110–275, § 154(d)(3)(A), redesignated par. (10) as (11).

Subsec. (b)(11)(C). Pub. L. 110–275, § 154(d)(4)(A), inserted ''and the identification of areas under subsection (a)(1)(D)(iii)'' after ''(a)(1)(A)''.

Subsec. (b)(11)(D). Pub. L. 110–275, § 154(d)(4)(B), inserted ''and implementation of subsection (a)(1)(D)'' after ''(a)(1)(B)''.

Subsec. (b)(11)(G). Pub. L. 110–275, § 154(d)(4)(C)–(E), added subpar. (G).

Subsec. (c)(5). Pub. L. 110–275, § 154(c)(2)(A), substituted ''December 31, 2011'' for ''December 31, 2009''.

Subsec. (d). Pub. L. 110–275, § 154(c)(2)(B), substituted ''July 1, 2011'' for ''July 1, 2009''.

Subsec. (e). Pub. L. 110–275, § 145(a)(1), struck out subsec. (e) which related to a demonstration project on the application of competitive acquisition to clinical diagnostic laboratory tests, terms and conditions of the project, and reporting requirement.

Subsec. (f). Pub. L. 110–275, § 154(b)(3), added subsec. (f).

2003—Pub. L. 108–173 amended section catchline and text generally, substituting provisions relating to competitive acquisition of certain items and services for provisions relating to demonstration projects for competitive acquisition of items and services.

1999—Subsec. (b)(2). Pub. L. 106–113 inserted ''and'' after ''specified by the Secretary''.

Statutory Notes and Related Subsidiaries

Effective Date of 2008 Amendment

Amendment by section 154 of Pub. L. 110–275 effective June 30, 2008, see section 154(e) of Pub. L. 110–275, set out as a note under section 1395m of this title.

Effective Date of 1999 Amendment

Amendment by Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Construction of 2015 Amendment

Pub. L. 114–10, title V, § 522(b)(2), Apr. 16, 2015, 129 Stat. 177, provided that: ''Nothing in the amendment made by paragraph (1) [amending this section] shall be construed as affecting the authority of the Secretary of Health and Human Services to require State licensure of an entity under the Medicare competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) before the date of the enactment of this Act [Apr. 16, 2015].''

Non-Application of Medicare Fee Schedule Adjustments for Wheelchair Accessories and Seat and Back Cushions When Furnished in Connection With Complex Rehabilitative Manual Wheelchairs

Pub. L. 116–94, div. N, title I, § 106(b), Dec. 20, 2019, 133 Stat. 3101, provided that:

''(1) In general.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, during the period beginning on January 1, 2020, and ending on June 30, 2021, use information on the payment determined under the competitive acquisition programs under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) to adjust the payment amount that would otherwise be recognized under section 1834(a)(1)(B)(ii) of such Act (42 U.S.C. 1395m(a)(1)(B)(ii)) for wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes).

''(2) Implementation.—Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise.''

Implementation of 2018 Amendment

Pub. L. 115–123, div. E, title IV, § 50414(c), Feb. 9, 2018, 132 Stat. 223, provided that:

''(1) Implementation.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, and amendments made by, this section [amending this section] by program instruction or otherwise.

''(2) Non-application of the paperwork reduction act.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995'), shall not apply to this section or the amendments made by this section.''

GAO Report on Impact of Competitive Acquisition on Suppliers

Pub. L. 108–173, title III, § 302(b)(3), Dec. 8, 2003, 117 Stat. 2230, as amended by Pub. L. 110–275, title I, § 154(c)(1), July 15, 2008, 122 Stat. 2565, provided that:

''(A) Study.—The Comptroller General of the United States shall conduct a study on the impact of competitive acquisition of durable medical equipment under section 1847 of the Social Security Act [42 U.S.C. 1395w–3], as amended by paragraph (1) and as amended by section 2 of the Medicare DMEPOS Competitive Acquisition Reform Act of 2008 [probably should refer to section 154 of the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–275], on suppliers and manufacturers of such equipment and on patients. Such study shall specifically examine the impact of such competitive acquisition on access to, and quality of, such equipment and service related to such equipment and the topics specified in subparagraph (C).

''(B) Report.—Not later than 1 year after the first date that payments are made under section 1847 of the Social Security Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A) and shall include in the report such

recommendations as the Comptroller General determines appropriate.

''(C) TOPICS.—The topics specified in this subparagraph, for the study under subparagraph (A) concerning the competitive acquisition program, are the following:

''(i) Beneficiary access to items and services under the program, including the impact on such access of awarding contracts to bidders that—

''(I) did not have a physical presence in an area where they received a contract; or

''(II) had no previous experience providing the product category they were contracted to provide.

''(ii) Beneficiary satisfaction with the program and cost savings to beneficiaries under the program.

''(iii) Costs to suppliers of participating in the program and recommendations about ways to reduce those costs without compromising quality standards or savings to the Medicare program.

''(iv) Impact of the program on small business suppliers.

''(v) Analysis of the impact on utilization of different items and services paid within the same Healthcare Common Procedure Coding System (HCPCS) code.

''(vi) Costs to the Centers for Medicare & Medicaid Services, including payments made to contractors, for administering the program compared with administration of a fee schedule, in comparison with the relative savings of the program.

''(vii) Impact on access, Medicare spending, and beneficiary spending of any difference in treatment for diabetic testing supplies depending on how such supplies are furnished.

''(viii) Such other topics as the Comptroller General determines to be appropriate.''

REPORT ON ACTIVITIES OF SUPPLIERS

Pub. L. 108–173, title III, §302(e), Dec. 8, 2003, 117 Stat. 2233, as amended by Pub. L. 110–275, title I, §154(c)(2)(C), July 15, 2008, 122 Stat. 2566, provided that: ''The Inspector General of the Department of Health and Human Services shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act [42 U.S.C. 1395w–3], as amended by subsection (a) [probably should be (b)(1)], are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability. Not later than July 1, 2011, the Inspector General shall submit to Congress a report on such study.''

STUDY BY GAO

Pub. L. 105–33, title IV, §4319(c), Aug. 5, 1997, 111 Stat. 394, provided that: ''The Comptroller of the United States shall study the effectiveness of the establishment of competitive acquisition areas under section 1847(a) of the Social Security Act [42 U.S.C. 1395w–3(a)], as added by this section.''

§ 1395w–3a. Use of average sales price payment methodology

(a) Application

(1) In general

Except as provided in paragraph (2), this section shall apply to payment for drugs and biologicals that are described in section 1395u(*o*)(1)(C) of this title and that are furnished on or after January 1, 2005.

(2) Election

This section shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1395w–3b of this title for that section to apply instead of this section for the payment for drugs and biologicals.

(b) Payment amount

(1) In general

Subject to paragraph (7) and subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 106 percent of the amount determined under paragraph (3) for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008;

(B) in the case of a single source drug or biological (as defined in subsection (c)(6)(D)), 106 percent of the amount determined under paragraph (4); or

(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).

(2) Specification of unit

(A) Specification by manufacturer

The manufacturer of a drug or biological shall specify the unit associated with each National Drug Code (including package size) as part of the submission of data under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable.

(B) Unit defined

In this section, the term ''unit'' means, with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. For years after 2004, the Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section.

(3) Multiple source drug

For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable, determined by—

(A) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(i) the manufacturer's average sales price (as defined in subsection (c)); and

(ii) the total number of units specified under paragraph (2) sold; and

(B) dividing the sum determined under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all National Drug Codes assigned to such drug products.

(4) Single source drug or biological

The amount specified in this paragraph for a single source drug or biological is the lesser of the following:

(A) Average sales price

The average sales price as determined using the methodology applied under paragraph (3) for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008, for all National Drug Codes assigned to such drug or biological product.

(B) Wholesale acquisition cost (WAC)

The wholesale acquisition cost (as defined in subsection (c)(6)(B)) using the methodology applied under paragraph (3) for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008, for all National Drug Codes assigned to such drug or biological product.

(5) Basis for payment amount

The payment amount shall be determined under this subsection based on information reported under subsection (f) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(6) Use of volume-weighted average sales prices in calculation of average sales price

(A) In general

For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable, determined by—

(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(I) the manufacturer's average sales price (as defined in subsection (c)), determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code; and

(II) the total number of units specified under paragraph (2) sold; and

(ii) dividing the sum determined under clause (i) by the sum of the products (for each National Drug Code assigned to such drug products) of—

(I) the total number of units specified under paragraph (2) sold; and

(II) the total number of billing units for the National Drug Code for the billing and payment code.

(B) Billing unit defined

For purposes of this subsection, the term ''billing unit'' means the identifiable quantity associated with a billing and payment code, as established by the Secretary.

(7) Special rule

Beginning with April 1, 2008, the payment amount for—

(A) each single source drug or biological described in section 1395u(*o*)(1)(G) of this title that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii) is the lower of—

(i) the payment amount that would be determined for such drug or biological applying such subsection; or

(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

(B) a multiple source drug described in section 1395u(*o*)(1)(G) of this title (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.

(8) Biosimilar biological product

The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).

(c) Manufacturer's average sales price

(1) In general

For purposes of this section, subject to paragraphs (2) and (3), the manufacturer's ''average sales price'' means, of a drug or biological for a National Drug Code for a calendar quarter for a manufacturer for a unit—

(A) the manufacturer's sales to all purchasers (excluding sales exempted in paragraph (2)) in the United States for such drug or biological in the calendar quarter; divided by

(B) the total number of such units of such drug or biological sold by the manufacturer in such quarter.

(2) Certain sales exempted from computation

In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

(A) Sales exempt from best price

Sales exempt from the inclusion in the determination of ''best price'' under section 1396r–8(c)(1)(C)(i) of this title.

(B) Sales at nominal charge

Such other sales as the Secretary identifies as sales to an entity that are merely

nominal in amount (as applied for purposes of section 1396r–8(c)(1)(C)(ii)(III) of this title, except as the Secretary may otherwise provide).

(3) Sale price net of discounts

In calculating the manufacturer's average sales price under this subsection, such price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1396r–8 of this title). For years after 2004, the Secretary may include in such price other price concessions, which may be based on recommendations of the Inspector General, that would result in a reduction of the cost to the purchaser.

(4) Payment methodology in cases where average sales price during first quarter of sales is unavailable

In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section—

(A) in the case of a drug or biological furnished prior to January 1, 2019, based on—

(i) the wholesale acquisition cost; or

(ii) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals; and

(B) in the case of a drug or biological furnished on or after January 1, 2019—

(i) at an amount not to exceed 103 percent of the wholesale acquisition cost; or

(ii) based on the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.

(5) Frequency of determinations

(A) In general on a quarterly basis

The manufacturer's average sales price, for a drug or biological of a manufacturer, shall be calculated by such manufacturer under this subsection on a quarterly basis. In making such calculation insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks. For years after 2004, the Secretary may establish a uniform methodology under this subparagraph to estimate and apply such costs.

(B) Updates in payment amounts

The payment amounts under subsection (b) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price calculated for the most recent calendar quarter for which data is available.

(C) Use of contractors; implementation

The Secretary may contract with appropriate entities to calculate the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, any of the provisions of this section.

(6) Definitions and other rules

In this section:

(A) Manufacturer

The term ''manufacturer'' means, with respect to a drug or biological, the manufacturer (as defined in section 1396r–8(k)(5) of this title), except that, for purposes of subsection (f)(2), the Secretary may, if the Secretary determines appropriate, exclude repackagers of a drug or biological from such term.

(B) Wholesale acquisition cost

The term ''wholesale acquisition cost'' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(C) Multiple source drug

(i) In general

The term ''multiple source drug'' means, for a calendar quarter, a drug for which there are 2 or more drug products which—

(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of ''Approved Drug Products with Therapeutic Equivalence Evaluations''),

(II) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the United States during the quarter.

(ii) Exception

With respect to single source drugs or biologicals that are within the same billing and payment code as of October 1, 2003, the Secretary shall treat such single source drugs or biologicals as if the single source drugs or biologicals were multiple source drugs.

(D) Single source drug or biological

The term ''single source drug or biological'' means—

(i) a biological; or

(ii) a drug which is not a multiple source drug and which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(E) Exception from pharmaceutical equivalence and bioequivalence requirement

Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

(F) Determination of pharmaceutical equivalence and bioequivalence

For purposes of this paragraph—

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(G) Inclusion of vaccines

In applying provisions of section 1396r–8 of this title under this section, ''other than a vaccine'' is deemed deleted from section 1396r–8(k)(2)(B) of this title.

(H) Biosimilar biological product

The term ''biosimilar biological product'' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 262 of this title.

(I) Reference biological product

The term ''reference biological product'' means the biological product licensed under such section 262 of this title that is referred to in the application described in subparagraph (H) of the biosimilar biological product.

(d) Monitoring of market prices

(1) In general

The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.

(2) Comparison of prices

Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

(A) the widely available market price for such drugs and biologicals (if any); and

(B) the average manufacturer price (as determined under section 1396r–8(k)(1) of this title) for such drugs and biologicals.

(3) Limitation on average sales price

(A) In general

The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).

(B) Applicable threshold percentage defined

In this paragraph, the term ''applicable threshold percentage'' means—

(i) in 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and

(ii) in 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.

(C) Authority to adjust average sales price

If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

(i) the widely available market price for the drug or biological (if any); or

(ii) 103 percent of the average manufacturer price (as determined under section 1396r–8(k)(1) of this title) for the drug or biological.

(4) Civil money penalty

(A) Misrepresentation

If the Secretary determines that a manufacturer has made a misrepresentation in the reporting of the manufacturer's average sales price for a drug or biological, the Secretary may apply a civil money penalty in an amount of up to $10,000 for each such price misrepresentation and for each day in which such price misrepresentation was applied.

(B) Failure to provide timely information

If the Secretary determines that a manufacturer described in subsection (f)(2) has failed to report on information described in section 1396r–8(b)(3)(A)(iii) of this title with respect to a drug or biological in accordance with such subsection, the Secretary shall apply a civil money penalty in an amount of $10,000 for each day the manufacturer has failed to report such information and such amount shall be paid to the Treasury.

(C) False information

Any manufacturer required to submit information under subsection (f)(2) that know-

ingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law.

(D) Increasing oversight and enforcement

For calendar quarters beginning on or after January 1, 2022, section 1396r–8(b)(3)(C)(iv) of this title shall be applied as if—

(i) each reference to ''under this subparagraph and subsection (c)(4)(B)(ii)(III)'' were a reference to ''under this subparagraph, subsection (c)(4)(B)(ii)(III), and subparagraphs (A), (B), and (C) of section 1395w–3a(d)(4) of this title''; and

(ii) the reference to ''activities related to the oversight and enforcement of this section and agreements under this section'' were a reference to ''activities related to the oversight and enforcement of this section and under subsection (f)(2) of section 1395w–3a of this title and subparagraphs (A), (B), and (C) of this subsection 1395w–3a(d)(4) of this title and, if applicable, agreements under this section''.

(E) Procedures

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A), (B), or (C) in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(5) Widely available market price

(A) In general

In this subsection, the term ''widely available market price'' means the price that a prudent physician or supplier would pay for the drug or biological. In determining such price, the Inspector General shall take into account the discounts, rebates, and other price concessions routinely made available to such prudent physicians or suppliers for such drugs or biologicals.

(B) Considerations

In determining the price under subparagraph (A), the Inspector General shall consider information from one or more of the following sources:

(i) Manufacturers.
(ii) Wholesalers.
(iii) Distributors.
(iv) Physician supply houses.
(v) Specialty pharmacies.
(vi) Group purchasing arrangements.
(vii) Surveys of physicians.
(viii) Surveys of suppliers.
(ix) Information on such market prices from insurers.
(x) Information on such market prices from private health plans.

(e) Authority to use alternative payment in response to public health emergency

In the case of a public health emergency under section 247d of this title in which there is a documented inability to access drugs and biologicals, and a concomitant increase in the price,[1] of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug or biological price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

(f) Quarterly report on average sales price

(1) In general

For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the drug or biological under this section, see section 1396r–8(b)(3) of this title.

(2) Manufacturers without a rebate agreement under subchapter xix

(A) In general

If the manufacturer of a drug or biological described in subparagraph (C), (E), or (G) of section 1395u(*o*)(1) of this title or in section 1395rr(b)(14)(B) of this title that is payable under this part has not entered into and does not have in effect a rebate agreement described in subsection (b) of section 1396r–8 of this title, for calendar quarters beginning on January 1, 2022, such manufacturer shall report to the Secretary the information described in subsection (b)(3)(A)(iii) of such section 1396r–8 of this title with respect to such drug or biological in a time and manner specified by the Secretary. For purposes of applying this paragraph, a drug or biological described in the previous sentence includes items, services, supplies, and products that are payable under this part as a drug or biological.

(B) Audit

Information reported under subparagraph (A) is subject to audit by the Inspector General of the Department of Health and Human Services.

(C) Verification

The Secretary may survey wholesalers and manufacturers that directly distribute drugs or biologicals described in subparagraph (A), when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of such a drug or biological refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section

[1] So in original. The comma probably should not appear.

1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Confidentiality

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph (other than the wholesale acquisition cost for purposes of carrying out this section) is confidential and shall not be disclosed by the Secretary in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs or biologicals by such manufacturer or wholesaler, except—

(i) as the Secretary determines to be necessary to carry out this section (including the determination and implementation of the payment amount), or to carry out section 1320a–7b of this title;

(ii) to permit the Comptroller General of the United States to review the information provided;

(iii) to permit the Director of the Congressional Budget Office to review the information provided;

(iv) to permit the Medicare Payment Advisory Commission to review the information provided; and

(v) to permit the Medicaid and CHIP Payment and Access Commission to review the information provided.

(g) Payment adjustment for certain drugs for which there is a self-administered NDC

(1) OIG studies

The Inspector General of the Department of Health and Human Services shall conduct periodic studies to identify National Drug Codes for drug or biological products that are self-administered for which payment may not be made under this part because such products are not covered pursuant to section 1395x(s)(2) of this title and which the Inspector General determines (based on the same or similar methodologies to the methodologies used in the final recommendation followup report of the Inspector General described in paragraph (3) or in the November 2017 final report of the Inspector General entitled ''Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries'') should be excluded from the determination of the payment amount under this section.

(2) Payment adjustment

If the Inspector General identifies a National Drug Code for a drug or biological product under paragraph (1), the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this paragraph) and the Secretary shall, to the extent the Secretary deems appropriate, apply as the amount of payment under this section for the applicable billing and payment code the lesser of—

(A) the amount of payment that would be determined under this section for such billing and payment code if such National Drug Code for such product so identified under paragraph (1) were excluded from such determination; or

(B) the amount of payment otherwise determined under this section for such billing and payment code without application of this subsection.

(3) Application to certain identified products

In the case of a National Drug Code for a drug or biological product that is self-administered for which payment is not made under this part because such product is not covered pursuant to section 1395x(s)(2) of this title that was identified by the Inspector General of the Department of Health and Human Services in the final recommendation followup report of the Inspector General published July 2020, entitled Loophole in Drug Payment Rule Continues To Cost Medicare and Beneficiaries Hundreds of Millions of Dollars, beginning July 1, 2021, the amount of payment under this section for the applicable billing and payment code shall be the lesser of—

(A) the amount of payment that would be determined under this section for such billing and payment code if such National Drug Code for such drug or biological products so identified were excluded from such determination; or

(B) the amount of payment otherwise determined under this section for such billing and payment code without application of this subsection.

(h) Refund for certain discarded single-dose container or single-use package drugs

(1) Secretarial provision of information

(A) In general

For each calendar quarter beginning on or after January 1, 2023, the Secretary shall, with respect to a refundable single-dose container or single-use package drug (as defined in paragraph (8)), report to each manufacturer (as defined in subsection (c)(6)(A)) of such refundable single-dose container or single-use package drug the following for the calendar quarter:

(i) Subject to subparagraph (C), information on the total number of units of the billing and payment code of such drug, if any, that were discarded during such quarter, as determined using a mechanism such as the JW modifier used as of November 15, 2021 (or any such successor modifier that includes such data as determined appropriate by the Secretary).

(ii) The refund amount that the manufacturer is liable for pursuant to paragraph (3).

(B) Determination of discarded amounts

For purposes of subparagraph (A)(i), with respect to a refundable single-dose container or single-use package drug furnished during a quarter, the amount of such drug that was discarded shall be determined based on the amount of such drug that was unused and

discarded for each drug on the date of service.

(C) Exclusion of units of packaged drugs

The total number of units of the billing and payment code of a refundable single-dose container or single-use package drug of a manufacturer furnished during a calendar quarter for purposes of subparagraph (A)(i), and the determination of the estimated total allowed charges for the drug in the quarter for purposes of paragraph (3)(A)(ii), shall not include such units that are packaged into the payment amount for an item or service and are not separately payable.

(2) Manufacturer requirement

For each calendar quarter beginning on or after January 1, 2023, the manufacturer of a refundable single-dose container or single-use package drug shall, for such drug, provide to the Secretary a refund that is equal to the amount specified in paragraph (3) for such drug for such quarter.

(3) Refund amount

(A) In general

The amount of the refund specified in this paragraph is, with respect to a refundable single-dose container or single-use package drug of a manufacturer assigned to a billing and payment code for a calendar quarter beginning on or after January 1, 2023, an amount equal to the estimated amount (if any) by which—

(i) the product of—

(I) the total number of units of the billing and payment code for such drug that were discarded during such quarter (as determined under paragraph (1)); and

(II)(aa) in the case of a refundable single-dose container or single-use package drug that is a single source drug or biological, the amount of payment determined for such drug or biological under subsection (b)(1)(B) for such quarter; or

(bb) in the case of a refundable single-dose container or single-use package drug that is a biosimilar biological product, the amount of payment determined for such product under subsection (b)(1)(C) for such quarter; exceeds

(ii) an amount equal to the applicable percentage (as defined in subparagraph (B)) of the estimated total allowed charges for such drug under this part during the quarter.

(B) Applicable percentage defined

(i) In general

For purposes of subparagraph (A)(ii), the term ''applicable percentage'' means—

(I) subject to subclause (II), 10 percent; and

(II) if applicable, in the case of a refundable single-dose container or single-use package drug described in clause (ii), a percentage specified by the Secretary pursuant to such clause.

(ii) Treatment of drugs that have unique circumstances

In the case of a refundable single-dose container or single-use package drug that has unique circumstances involving similar loss of product as that described in paragraph (8)(B)(ii), the Secretary, through notice and comment rulemaking, may increase the applicable percentage otherwise applicable under clause (i)(I) as determined appropriate by the Secretary.

(4) Frequency

Amounts required to be refunded pursuant to paragraph (2) shall be paid in regular intervals (as determined appropriate by the Secretary).

(5) Refund deposits

Amounts paid as refunds pursuant to paragraph (2) shall be deposited into the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title.

(6) Enforcement

(A) Audits

(i) Manufacturer audits

Each manufacturer of a refundable single-dose container or single-use package drug that is required to provide a refund under this subsection shall be subject to periodic audit with respect to such drug and such refunds by the Secretary.

(ii) Provider audits

The Secretary shall conduct periodic audits of claims submitted under this part with respect to refundable single-dose container or single-use package drugs in accordance with the authority under section 1395*l*(e) of this title to ensure compliance with the requirements applicable under this subsection.

(B) Civil money penalty

(i) In general

The Secretary shall impose a civil money penalty on a manufacturer of a refundable single-dose container or single-use package drug who has failed to comply with the requirement under paragraph (2) for such drug for a calendar quarter in an amount equal to the sum of—

(I) the amount that the manufacturer would have paid under such paragraph with respect to such drug for such quarter; and

(II) 25 percent of such amount.

(ii) Application

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

(7) Implementation

The Secretary shall implement this subsection through notice and comment rulemaking.

(8) Definition of refundable single-dose container or single-use package drug

(A) In general

Except as provided in subparagraph (B), in this subsection, the term ''refundable single-

dose container or single-use package drug'' means a single source drug or biological (as defined in subsection (c)(6)(D)) or a biosimilar biological product (as defined in subsection (c)(6)(H)) for which payment is made under this part and that is furnished from a single-dose container or single-use package.

(B) Exclusions

The term ''refundable single-dose container or single-use package drug'' does not include—

(i) a drug or biological that is either a radiopharmaceutical or an imaging agent;

(ii) a drug or biological approved by the Food and Drug Administration for which dosage and administration instructions included in the labeling require filtration during the drug preparation process, prior to dilution and administration, and require that any unused portion of such drug after the filtration process be discarded after the completion of such filtration process; or

(iii) a drug or biological approved by the Food and Drug Administration on or after November 15, 2021, and with respect to which payment has been made under this part for fewer than 18 months.

(9) Report to Congress

Not later than 3 years after November 15, 2021, the Office of the Inspector General, after consultation with the Centers for Medicare & Medicaid Services and the Food and Drug Administration, shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report on any impact this section is reported to have on the licensure, market entry, market retention, or marketing of biosimilar biological products. Such report shall be updated periodically at the direction of the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives.

(i) Judicial review

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

(1) determinations of payment amounts under this section, including the assignment of National Drug Codes to billing and payment codes;

(2) the identification of units (and package size) under subsection (b)(2);

(3) the method to allocate rebates, chargebacks, and other price concessions to a quarter if specified by the Secretary;

(4) the manufacturer's average sales price when it is used for the determination of a payment amount under this section; and

(5) the disclosure of the average manufacturer price by reason of an adjustment under subsection (d)(3)(C) or (e).

(Aug. 14, 1935, ch. 531, title XVIII, § 1847A, as added Pub. L. 108–173, title III, § 303(c)(1), Dec. 8, 2003, 117 Stat. 2239; amended Pub. L. 110–173, title I, § 112, Dec. 29, 2007, 121 Stat. 2500; Pub. L. 111–148, title III, § 3139(a), Mar. 23, 2010, 124 Stat. 439; Pub. L. 116–39, § 6, Aug. 6, 2019, 133 Stat. 1062; Pub. L. 116–260, div. CC, title IV, §§ 401(a), (b), 405, Dec. 27, 2020, 134 Stat. 2995, 2996, 3002; Pub. L. 117–58, div. I, § 90004, Nov. 15, 2021, 135 Stat. 1343.)

Editorial Notes

AMENDMENTS

2021—Subsecs. (h), (i). Pub. L. 117–58 added subsec. (h) and redesignated former subsec. (h) as (i).

2020—Subsec. (b)(2)(A). Pub. L. 116–260, § 401(a)(1)(A), inserted ''or subsection (f)(2), as applicable'' before period at end.

Subsec. (b)(3). Pub. L. 116–260, § 401(a)(1)(B), inserted ''or subsection (f)(2), as applicable,'' before ''determined by'' in introductory provisions.

Subsec. (b)(6)(A). Pub. L. 116–260, § 401(a)(1)(C), inserted ''or subsection (f)(2), as applicable,'' before ''determined by'' in introductory provisions.

Subsec. (c)(6)(A). Pub. L. 116–260, § 401(b)(2), substituted '', except that, for purposes of subsection (f)(2), the Secretary may, if the Secretary determines appropriate, exclude repackagers of a drug or biological from such term.'' for period at end.

Subsec. (d)(4)(A). Pub. L. 116–260, § 401(b)(1)(A), substituted ''Misrepresentation'' for ''In general'' in heading.

Subsec. (d)(4)(B). Pub. L. 116–260, § 401(b)(1)(D), added subpar. (B). Former subpar. (B) redesignated (E).

Pub. L. 116–260, § 401(b)(1)(B), substituted ''subparagraph (A), (B), or (C)'' for ''subparagraph (B)''.

Subsec. (d)(4)(C), (D). Pub. L. 116–260, § 401(b)(1)(D), added subpars. (C) and (D).

Subsec. (d)(4)(E). Pub. L. 116–260, § 401(b)(1)(C), redesignated subpar. (B) as (E).

Subsec. (f). Pub. L. 116–260, § 401(a)(2), designated existing provisions as par. (1), inserted heading, and added par. (2).

Subsecs. (g), (h). Pub. L. 116–260, § 405, added subsec. (g) and redesignated former subsec. (g) as (h).

2019—Subsec. (c)(4). Pub. L. 116–39 substituted ''payable under this section—'' for ''payable under this section for the drug or biological based on—'' in introductory provisions, added subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows:

''(A) the wholesale acquisition cost; or

''(B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.''

2010—Subsec. (b)(1)(C). Pub. L. 111–148, § 3139(a)(1)(A), added subpar. (C).

Subsec. (b)(8). Pub. L. 111–148, § 3139(a)(1)(B), added par. (8).

Subsec. (c)(6)(H), (I). Pub. L. 111–148, § 3139(a)(2), added subpars. (H) and (I).

2007—Subsec. (b)(1). Pub. L. 110–173, § 112(b)(1), inserted ''paragraph (7) and'' after ''Subject to'' in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 110–173, § 112(a)(1), inserted ''for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008'' after ''paragraph (3)''.

Subsec. (b)(4)(A), (B). Pub. L. 110–173, § 112(a)(2), inserted ''for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008,'' after ''paragraph (3)''.

Subsec. (b)(6). Pub. L. 110–173, § 112(a)(3), added par. (6).

Subsec. (b)(7). Pub. L. 110–173, § 112(b)(2), added par. (7).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, § 3139(b), Mar. 23, 2010, 124 Stat. 440, provided that: ''The amendments made by

subsection (a) [amending this section] shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary [probably means the Secretary of Health and Human Services]).''

REPORT ON SALES TO PHARMACY BENEFIT MANAGERS

Pub. L. 108–173, title III, §303(c)(2), Dec. 8, 2003, 117 Stat. 2245, provided that:

''(A) STUDY.—The Secretary [of Health and Human Services] shall conduct a study on sales of drugs and biologicals to large volume purchasers, such as pharmacy benefit managers and health maintenance organizations, for purposes of determining whether the price at which such drugs and biologicals are sold to such purchasers does not represent the price such drugs and biologicals are made available for purchase to prudent physicians.

''(B) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations on whether such sales to large volume purchasers should be excluded from the computation of a manufacturer's average sales price under section 1847A of the Social Security Act [42 U.S.C. 1395w–3a], as added by paragraph (1).''

INSPECTOR GENERAL REPORT ON ADEQUACY OF REIMBURSEMENT RATE UNDER AVERAGE SALES PRICE METHODOLOGY

Pub. L. 108–173, title III, §303(c)(3), Dec. 8, 2003, 117 Stat. 2245, provided that:

''(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the ability of physician practices in the specialties of hematology, hematology/oncology, and medical oncology of different sizes, especially particularly large practices, to obtain drugs and biologicals for the treatment of cancer patients at 106 percent of the average sales price for the drugs and biologicals. In conducting the study, the Inspector General shall conduct an audit of a representative sample of such practices to determine the adequacy of reimbursement under section 1847A of the Social Security Act [42 U.S.C. 1395w–3a], as added by paragraph (1).

''(B) REPORT.—Not later October 1, 2005, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A), and shall include recommendations on the adequacy of reimbursement for such drugs and biologicals under such section 1847A [42 U.S.C. 1395w–3a].''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

§ 1395w–3b. Competitive acquisition of outpatient drugs and biologicals

(a) Implementation of competitive acquisition

(1) Implementation of program

(A) In general

The Secretary shall establish and implement a competitive acquisition program under which—

(i) competitive acquisition areas are established for contract award purposes for acquisition of and payment for categories of competitively biddable drugs and biologicals (as defined in paragraph (2)) under this part;

(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program, rather than under section 1395w–3a of this title; and

(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

This section shall not apply in the case of a physician who elects section 1395w–3a of this title to apply.

(B) Implementation

For purposes of implementing the program, the Secretary shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.

(C) Waiver of certain provisions

In order to promote competition, in carrying out the program the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Exclusion authority

The Secretary may exclude competitively biddable drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the application of competitive bidding to such drugs or biologicals—

(i) is not likely to result in significant savings; or

(ii) is likely to have an adverse impact on access to such drugs or biologicals.

(2) Competitively biddable drugs and biologicals and program defined

For purposes of this section—

(A) Competitively biddable drugs and biologicals defined

The term ''competitively biddable drugs and biologicals'' means a drug or biological described in section 1395u(*o*)(1)(C) of this title and furnished on or after January 1, 2006.

(B) Program

The term ''program'' means the competitive acquisition program under this section.

(C) Competitive acquisition area; area

The terms ''competitive acquisition area'' and ''area'' mean an appropriate geographic region established by the Secretary under the program.

(D) Contractor

The term ''contractor'' means an entity that has entered into a contract with the Secretary under this section.

(3) Application of program payment methodology

(A) In general

With respect to competitively biddable drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has elected this section to apply—

(i) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

(ii) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contractor and shall not be collected unless the drug or biological is administered to the individual involved; and

(iii) the payment under this section (and related amounts of any applicable deductible and coinsurance) for such drugs and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary.

(B) Process for adjustments

The Secretary shall provide a process for adjustments to payments in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

(C) Information for purposes of cost-sharing

The Secretary shall provide a process by which physicians submit information to contractors for purposes of the collection of any applicable deductible or coinsurance amounts under subparagraph (A)(ii).

(D) Post-payment review process

The Secretary shall establish (by program instruction or otherwise) a post-payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological under this section only if the drug or biological has been administered to a beneficiary. The Secretary shall recoup, offset, or collect any overpayments determined by the Secretary under such process.

(4) Contract required

Payment may not be made under this part for competitively biddable drugs and biologicals prescribed by a physician who has elected this section to apply within a category and a competitive acquisition area with respect to which the program applies unless—

(A) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

(B) the physician has elected such contractor under paragraph (5) for such category and area.

(5) Contractor selection process

(A) Annual selection

(i) In general

The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of competitively biddable drugs and biologicals for an area by selecting physicians.

(ii) Timing of selection

The selection of a contractor under clause (i) shall be made at the time of the election described in section 1395w–3a(a) of this title for this section to apply and shall be coordinated with agreements entered into under section 1395u(h) of this title.

(B) Information on contractors

The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Internet website of the Centers for Medicare & Medicaid Services or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

(C) Selecting physician defined

For purposes of this section, the term ''selecting physician'' means, with respect to a contractor and category and competitive acquisition area, a physician who has elected this section to apply and has selected to apply under this section such contractor for such category and area.

(b) Program requirements

(1) Contract for competitively biddable drugs and biologicals

The Secretary shall conduct a competition among entities for the acquisition of competitively biddable drugs and biologicals. Notwithstanding any other provision of this subchapter, in the case of a multiple source drug, the Secretary shall conduct such competition among entities for the acquisition of at least one competitively biddable drug and biological within each billing and payment code within each category for each competitive acquisition area.

(2) Conditions for awarding contract

(A) In general

The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of competitively biddable drugs and biologicals within a category unless the

Secretary finds that the entity meets all of the following with respect to the contract period involved:

(i) Capacity to supply competitively biddable drug or biological within category

(I) In general

The entity has sufficient arrangements to acquire and to deliver competitively biddable drugs and biologicals within such category in the area specified in the contract.

(II) Shipment methodology

The entity has arrangements in effect for the shipment at least 5 days each week of competitively biddable drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

(ii) Quality, service, financial performance and solvency standards

The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including—

(I) the establishment of procedures for the prompt response and resolution of complaints of physicians and individuals and of inquiries regarding the shipment of competitively biddable drugs and biologicals; and

(II) a grievance and appeals process for the resolution of disputes.

(B) Additional considerations

The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon—

(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

(ii) the exclusion of the entity under section 1320a–7 of this title from participation under this subchapter.

(C) Application of Medicare Provider Ombudsman

For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1395ee(b) of this title, as added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1]

(3) Awarding multiple contracts for a category and area

The Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

(A) The bid prices for competitively biddable drugs and biologicals within the category and area.

(B) Bid price for distribution of such drugs and biologicals.

(C) Ability to ensure product integrity.

(D) Customer service.

(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

(F) Such other factors as the Secretary may specify.

(4) Terms of contracts

(A) In general

A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

(B) Period of contracts

A contract under this section shall be for a term of 3 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

(C) Integrity of drug and biological distribution system

A contractor (as defined in subsection (a)(2)(D)) shall—

(i) acquire all drug and biological products it distributes directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

(ii) comply with any product integrity safeguards as may be determined to be appropriate by the Secretary.

Nothing in this subparagraph shall be construed to relieve or exempt any contractor from the provisions of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] that relate to the wholesale distribution of prescription drugs or biologicals.

(D) Compliance with code of conduct and fraud and abuse rules

Under the contract—

(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

(E) Direct delivery of drugs and biologicals to physicians

Under the contract the contractor shall only supply competitively biddable drugs and biologicals directly to the selecting physicians and not directly to individuals, except under circumstances and settings where an individual currently receives a drug or biological in the individual's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

[1] See References in Text note below.

(i) require a physician to submit a prescription for each individual treatment; or

(ii) change a physician's flexibility in terms of writing a prescription for drugs or biologicals for a single treatment or a course of treatment.

(5) Permitting access to drugs and biologicals

The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

(A) The drugs or biologicals are required immediately.

(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

(D) The drugs or biologicals were administered in an emergency situation.

(6) Construction

Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

(c) Bidding process

(1) In general

In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the bid price and the other factors referred to in subsection (b)(3).

(2) Bid defined

In this section, the term ''bid'' means an offer to furnish a competitively biddable drug or biological for a particular price and time period.

(3) Bidding on a national or regional basis

Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

(4) Uniformity of bids within area

The amount of the bid submitted under a contract offer for any competitively biddable drug or biological for an area shall be the same for that drug or biological for all portions of that area.

(5) Confidentiality of bids

The provisions of subparagraph (D) of section 1396r–8(b)(3) of this title shall apply to periods during which a bid is submitted with respect to a competitively biddable drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference—

(A) in that subparagraph to a ''manufacturer or wholesaler'' is deemed a reference to a ''bidder'' under this section;

(B) in that section to ''prices charged for drugs'' is deemed a reference to a ''bid'' submitted under this section; and

(C) in clause (i) of that section to ''this section'', is deemed a reference to ''part B of subchapter XVIII''.

(6) Inclusion of costs

The bid price submitted in a contract offer for a competitively biddable drug or biological shall—

(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

(7) Price adjustments during contract period; disclosure of costs

Each contract awarded shall provide for—

(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

(d) Computation of payment amounts

(1) In general

Payment under this section for competitively biddable drugs or biologicals shall be based on bids submitted and accepted under this section for such drugs or biologicals in an area. Based on such bids the Secretary shall determine a single payment amount for each competitively biddable drug or biological in the area.

(2) Special rules

The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1395w–3a of this title to the use of a price for specific competitively biddable drugs and biologicals in the following cases:

(A) New drugs and biologicals

A competitively biddable drug or biological for which a payment and billing code has not been established.

(B) Other cases

Such other exceptional cases as the Secretary may specify in regulations.

(e) Cost-sharing

(1) Application of coinsurance

Payment under this section for competitively biddable drugs and biologicals shall be in an amount equal to 80 percent of the payment basis described in subsection (d)(1).

(2) Deductible

Before applying paragraph (1), the individual shall be required to meet the deductible described in section 1395*l*(b) of this title.

(3) Collection

Such coinsurance and deductible shall be collected by the contractor that supplies the drug or biological involved. Subject to subsection (a)(3)(B), such coinsurance and deductible may be collected in a manner similar to the manner in which the coinsurance and deductible are collected for durable medical equipment under this part.

(f) Special payment rules

(1) Use in exclusion cases

If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for payment to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1395w–3a of this title.

(2) Application of requirement for assignment

For provision requiring assignment of claims for competitively biddable drugs and biologicals, see section 1395u(*o*)(3) of this title.

(3) Protection for beneficiary in case of medical necessity denial

For protection of individuals against liability in the case of medical necessity determinations, see section 1395u(b)(3)(B)(ii)(III) of this title.

(g) Judicial review

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

(1) the establishment of payment amounts under subsection (d)(1);

(2) the awarding of contracts under this section;

(3) the establishment of competitive acquisition areas under subsection (a)(2)(C);

(4) the phased-in implementation under subsection (a)(1)(B);

(5) the selection of categories of competitively biddable drugs and biologicals for competitive acquisition under such subsection or the selection of a drug in the case of multiple source drugs; or

(6) the bidding structure and number of contractors selected under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1847B, as added Pub. L. 108–173, title III, §303(d)(1), Dec. 8, 2003, 117 Stat. 2245; amended Pub. L. 109–432, div. B, title I, §108(a), Dec. 20, 2006, 120 Stat. 2983.)

Editorial Notes

REFERENCES IN TEXT

Section 1395ee(b) of this title, referred to in subsec. (b)(2)(C), was added by section 942(a)(5) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, not section 923 of that Act, and relates to the Council for Technology and Innovation, not to the Medicare Provider Ombudsman.

The Federal Food, Drug, and Cosmetic Act, referred to in subsec. subsec. (b)(4)(C), is act June 25, 1938, ch. 675, 52 Stat. 1040, as amended, which is classified generally to chapter 9 (§301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

AMENDMENTS

2006—Subsec. (a)(3)(A)(iii). Pub. L. 109–432, §108(a)(1), substituted ''and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary.'' for ''and biologicals—

''(I) shall be made only to such contractor; and

''(II) shall be conditioned upon the administration of such drugs and biologicals.''

Subsec. (a)(3)(D). Pub. L. 109–432, §108(a)(2), added subpar. (D).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(c), Dec. 20, 2006, 120 Stat. 2983, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payment for drugs and biologicals supplied under section 1847B of the Social Security Act (42 U.S.C. 1395w–3b)—

''(1) on or after April 1, 2007; and

''(2) on or after July 1, 2006, and before April 1, 2007, for claims that are unpaid as of April 1, 2007.''

CONSTRUCTION OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(b), Dec. 20, 2006, 120 Stat. 2983, provided that: ''Nothing in this section [amending this section and enacting provisions set out as a note above] shall be construed as—

''(1) requiring the conduct of any additional competition under subsection (b)(1) of section 1847B of the Social Security Act (42 U.S.C. 1395w–3b); or

''(2) requiring any additional process for elections by physicians under subsection (a)(1)(A)(ii) of such section or additional selection by a selecting physician of a contractor under subsection (a)(5) of such section.''

REPORT

Pub. L. 108–173, title III, §303(d)(2), Dec. 8, 2003, 117 Stat. 2252, provided that: ''Not later than July 1, 2008, the Secretary [of Health and Human Services] shall submit to Congress a report on the program conducted under section 1847B of the Social Security Act [42 U.S.C. 1395w–3b], as added by paragraph (1). Such report shall include information on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to physicians, the satisfaction of physicians and of individuals enrolled under this part [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], and information comparing prices for drugs and biologicals under such section and section 1847A of such Act [42 U.S.C. 1395w–3a], as added by subsection (c).''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

§1395w–4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this

part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the ''fee schedule amount'').

(2) Transition to full fee schedule

(A) Limiting reductions and increases to 15 percent in 1992

(i) Limit on increase

In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) Limit in reduction

In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) Special rule for 1993, 1994, and 1995

If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) Special rule for anesthesia and radiology services

With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, ''109 percent'' and ''9 percent'' shall be substituted for ''115 percent'' and ''15 percent'', respectively, in subparagraph (A)(ii).

(D) "Adjusted historical payment basis" defined

(i) In general

In this paragraph, the term ''adjusted historical payment basis'' means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) Application to radiology services

In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1395m(b) of this title.

(iii) Nuclear medicine services

In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) Incentives for participating physicians and suppliers

In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee sched-

ule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) Special rule for medical direction

(A) In general

With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, except as provided in paragraph (5), the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) Amount

The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.

(ii) For services furnished during 1995, 115 percent.

(iii) For services furnished during 1996, 110 percent.

(iv) For services furnished during 1997, 105 percent.

(v) For services furnished after 1997, 100 percent.

(5) Incentives for electronic prescribing

(A) Adjustment

(i) In general

Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012, 2013 or 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term ''applicable percent'' means—

(I) for 2012, 99 percent;

(II) for 2013, 98.5 percent; and

(III) for 2014, 98 percent.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

(C) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(D) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(iii) Reporting period

The term ''reporting period'' means, with respect to a year, a period specified by the Secretary.

(6) Special rule for teaching anesthesiologists

With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(7) Incentives for meaningful use of certified EHR technology

(A) Adjustment

(i) In general

Subject to subparagraphs (B) and (D), with respect to covered professional serv-

ices furnished by an eligible professional during each of 2015 through 2018, if the eligible professional is not a meaningful EHR user (as determined under subsection (*o*)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

Subject to clause (iii), for purposes of clause (i), the term ''applicable percent'' means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under subsection (a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018, 97 percent.

(iii) Authority to decrease applicable percentage for 2018

For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (*o*)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis (and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016), exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

(C) Application of physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(D) Non-application to hospital-based and ambulatory surgical center-based eligible professionals

(i) Hospital-based

No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (*o*)(1)(C)(ii)).

(ii) Ambulatory surgical center-based

Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

(iii) Determination

The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

(I) the site of service (as defined by the Secretary); or

(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

(iv) Sunset

Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.

(E) Definitions

For purposes of this paragraph:

(i) Covered professional services

The term ''covered professional services'' has the meaning given such term in subsection (k)(3).

(ii) EHR reporting period

The term ''EHR reporting period'' means, with respect to a year, a period (or periods) specified by the Secretary.

(iii) Eligible professional

The term ''eligible professional'' means a physician, as defined in section 1395x(r) of this title.

(8) Incentives for quality reporting

(A) Adjustment

(i) In general

With respect to covered professional services furnished by an eligible profes-

sional during each of 2015 through 2018, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term ''applicable percent'' means—

(I) for 2015, 98.5 percent; and

(II) for 2016, 2017, and 2018, 98 percent.

(B) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(iii) Quality reporting period

The term ''quality reporting period'' means, with respect to a year, a period specified by the Secretary.

(9) Information reporting on services included in global surgical packages

With respect to services for which a physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.

(b) Establishment of fee schedules

(1) In general

Before November 1 of the preceding year, for each year beginning with 1998, subject to subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) Treatment of radiology services and anesthesia services

(A) Radiology services

With respect to radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), the Secretary shall base the relative values on the relative value scale developed under section 1395m(b)(1)(A) of this title, with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) Anesthesia services

In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) Consultation

The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) Treatment of interpretation of electrocardiograms

The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

(4) Special rule for imaging services

(A) In general

In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1395*l*(t) of this title for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

(B) Imaging services described

For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010, 2011, and the first 2 months of 2012, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C) Adjustment in imaging utilization rate

With respect to fee schedules established for 2011, 2012, and 2013, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule. With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.

(D) Adjustment in technical component discount on single-session imaging involving consecutive body parts

For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(5) Treatment of intensive cardiac rehabilitation program

(A) In general

In the case of an intensive cardiac rehabilitation program described in section 1395x(eee)(4) of this title, the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1395*l*(t) of this title for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

(B) Definition of session

Each of the services described in subparagraphs (A) through (E) of section 1395x(eee)(3) of this title, when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

(C) Multiple sessions per day

Payment may be made for up to 6 sessions per day of the series of 72 one-hour sessions of intensive cardiac rehabilitation services described in section 1395x(eee)(4)(B) of this title.

(6) Treatment of bone mass scans

For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010, 2011, and the first 2 months of 2012, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010, 2011, and the first 2 months of 2012, respectively.

(7) Adjustment in discount for certain multiple therapy services

In the case of therapy services furnished on or after January 1, 2011, and before April 1, 2013, and for which payment is made under fee schedules established under this section, instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 20 percent. In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.

(8) Encouraging care management for individuals with chronic care needs

(A) In general

In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a phy-

sician (as defined in section 1395x(r)(1) of this title), physician assistant or nurse practitioner (as defined in section 1395x(aa)(5)(A) of this title), clinical nurse specialist (as defined in section 1395x(aa)(5)(B) of this title), or certified nurse midwife (as defined in section 1395x(gg)(2) of this title).

(B) Policies relating to payment

In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this subchapter for such services; and

(iii) not require that an annual wellness visit (as defined in section 1395x(hhh) of this title) or an initial preventive physical examination (as defined in section 1395x(ww) of this title) be furnished as a condition of payment for such management services.

(9) Special rule to incentivize transition from traditional X-ray imaging to digital radiography

(A) Limitation on payment for film X-ray imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 20 percent.

(B) Phased-in limitation on payment for computed radiography imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology—

(i) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 7 percent; and

(ii) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 10 percent.

(C) Computed radiography technology defined

For purposes of this paragraph, the term ''computed radiography technology'' means cassette-based imaging which utilizes an imaging plate to create the image involved.

(D) Implementation

In order to implement this paragraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(10) Reduction of discount in payment for professional component of multiple imaging services

In the case of the professional component of imaging services furnished on or after January 1, 2017, instead of the 25 percent reduction for multiple procedures specified in the final rule published by the Secretary in the Federal Register on November 28, 2011, as amended in the final rule published by the Secretary in the Federal Register on November 16, 2012, the reduction percentage shall be 5 percent.

(11) Special rule for certain radiation therapy services

The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017, 2018, and 2019 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

(c) Determination of relative values for physicians' services

(1) Division of physicians' services into components

In this section, with respect to a physicians' service:

(A) "Work component" defined

The term ''work component'' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) "Practice expense component" defined

The term ''practice expense component'' means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) "Malpractice component" defined

The term ''malpractice component'' means the portion of the resources used in fur-

nishing the service that reflects malpractice expenses in furnishing the service.

(2) Determination of relative values

(A) In general

(i) Combination of units for components

The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993.

(ii) Extrapolation

The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) Periodic review and adjustments in relative values

(i) Periodic review

The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) Adjustments

(I) In general

The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II) and paragraph (7), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) Limitation on annual adjustments

Subject to clauses (iv) and (v), the adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) Consultation

The Secretary, in making adjustments under clause (ii), shall consult with the Medicare Payment Advisory Commission and organizations representing physicians.

(iv) Exemption of certain additional expenditures from budget neutrality

The additional expenditures attributable to—

(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II);

(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year;

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010, 2011, or the first 2 months of 2012; and

(V) subsection (t) shall not be taken into account in applying clause (ii)(II) for 2021 or 2022.

(v) Exemption of certain reduced expenditures from budget-neutrality calculation

The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) Reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.

(II) OPD payment cap for imaging services

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) Change in utilization rate for certain imaging services

Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of subsection (b)(4)(C).

(IV), (V) Repealed. Pub. L. 111–152, title I, § 1107(2), Mar. 30, 2010, 124 Stat. 1050

(VI) Additional reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).

(VII) Reduced expenditures for multiple therapy services

Effective for fee schedules established beginning with 2011, reduced expendi-

tures attributable to the multiple procedure payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) Reduced expenditures attributable to application of quality incentives for computed tomography

Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1395m(p) of this title[1]

(IX) Reductions for misvalued services if target not met

Effective for fee schedules beginning with 2016, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

(X) Reduced expenditures attributable to incentives to transition to digital radiography

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subparagraph (A) of subsection (b)(9) and effective for fee schedules established beginning with 2018, reduced expenditures attributable to subparagraph (B) of such subsection.

(XI) Discount in payment for professional component of imaging services

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subsection (b)(10).

(vi) Alternative application of budget-neutrality adjustment

Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for years beginning with 2009.

(C) Computation of relative value units for components

For purposes of this section for each physicians' service—

(i) Work relative value units

The Secretary shall determine a number of work relative value units for the service or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services.

(ii) Practice expense relative value units

The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service or group of services. For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) Malpractice relative value units

The Secretary shall determine a number of malpractice relative value units for the service or group of services for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service or group of services, and

(II) the malpractice percentage for the service or group of services (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service or group of services.

(D) "Base allowed charges" defined

In this paragraph, the term ''base allowed charges'' means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) Reduction in practice expense relative value units for certain services

(i) In general

Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) Floor on reductions

The practice expense relative value units for a physician's service shall not be re-

[1] So in original. Probably should be followed by a period.

duced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) Excluded services

For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(F) Budget neutrality adjustments

The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and, in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) Adjustments in relative value units for 1998

(i) In general

The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) Excluded services

For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(iv) Limitation on aggregate reallocation

If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) No reduction for certain services

Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(H) Adjustments in practice expense relative value units for certain drug administration services beginning in 2004

(i) Use of survey data

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

(I) covers practice expenses for oncology drug administration services; and

(II) meets criteria established by the Secretary for acceptance of such surveys.

(ii) Pricing of clinical oncology nurses in practice expense methodology

If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

(iii) Work relative value units for certain drug administration services

In establishing the relative value units under this paragraph for drug administra-

tion services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

(iv) Drug administration services described

The drug administration services described in this clause are physicians' services—

(I) which are classified as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

(II) for which there are no work relative value units assigned under this subsection as of such date; and

(III) for which national relative value units have been assigned under this subsection as of such date.

(I) Adjustments in practice expense relative value units for certain drug administration services beginning with 2005

(i) In general

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

(ii) Use of supplemental survey data

(I) In general

Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1395u(*o*) of this title, the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(II) Limitation on specialty

Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this subchapter in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

(III) Application

This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

(J) Provisions for appropriate reporting and billing for physicians' services associated with the administration of covered outpatient drugs and biologicals

(i) Evaluation of codes

The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

(ii) Use of existing processes

In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

(iii) Implementation

In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1395w–3a of this title or section 1395w–3b of this title, and shall take such steps within the Secretary's authority to expedite such considerations under clause (ii).

(iv) Subsequent, budget neutral adjustments permitted

Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.

(K) Potentially misvalued codes

(i) In general

The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) Identification of potentially misvalued codes

For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) Review and adjustments

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) and paragraph (7) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

(iv) Treatment of certain radiation therapy services

Radiation treatment delivery and related imaging services identified under subsection (b)(11) shall not be considered as potentially misvalued services for purposes of this subparagraph and subparagraph (O) for 2017, 2018, and 2019.

(L) Validating relative value units

(i) In general

The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) Components and elements of work

The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) Scope of codes

The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) Methods

The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) Adjustments

The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(M) Authority to collect and use information on physicians' services in the determination of relative values

(i) Collection of information

Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) Use of information

Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) Types of information

The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) Information collection mechanisms

Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) Transparency of use of information

(I) In general

Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) Thresholds for use

The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) Disclosure of information

The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

(vi) Incentive to participate

The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) Administration

Chapter 35 of title 44 shall not apply to information collected or obtained under this subparagraph.

(viii) Definition of eligible professional

In this subparagraph, the term ''eligible professional'' has the meaning given such term in subsection (k)(3)(B).

(ix) Funding

For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.

(N) Authority for alternative approaches to establishing practice expense relative values

The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) Target for relative value adjustments for misvalued services

With respect to fee schedules established for each of 2016 through 2018, the following shall apply:

(i) Determination of net reduction in expenditures

For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) Budget neutral redistribution of funds if target met and counting overages towards the target for the succeeding year

If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of de-

termining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) Exemption from budget neutrality if target not met

If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2016.

(iv) Target recapture amount

For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) Target

For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent (or, for 2016, 1.0 percent) of the estimated amount of expenditures under the fee schedule under this section for the year.

(3) Component percentages

For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) Division of services by specialty

For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) Division of specialty by component

The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) Determination of component percentages

(i) Work percentage

The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) Practice expense percentage

For years before 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) Malpractice percentage

For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) Periodic recomputation

The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) Ancillary policies

The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) Coding

The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) No variation for specialists

The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(7) Phase-in of significant relative value unit (RVU) reductions

Effective for fee schedules established beginning with 2016, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the

total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(8) Global surgical packages

(A) Prohibition of implementation of rule regarding global surgical packages

(i) In general

The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

(ii) Construction

Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

(B) Collection of data on services included in global surgical packages

(i) In general

Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1395t of this title $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

(ii) Reassessment and potential sunset

Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

(iii) Inspector general audit

The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

(C) Improving accuracy of pricing for surgical services

For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

(d) Conversion factors

(1) Establishment

(A) In general

The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001 and ending with 2025, multiplied by the update (established under paragraph (4) or a subsequent paragraph) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title) (referred to in this subsection as the ''qualifying APM conversion factor'') and the other for other items and services (referred to in this subsection as the ''nonqualifying APM conversion factor''), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.

(B) Special provision for 1992

For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) Special rules for 1998

Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) Special rules for anesthesia services

The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor (or, beginning with 2026, applicable conversion

factor) established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) Publication and dissemination of information

The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(2) Repealed. Pub. L. 105–33, title IV, § 4502(b), Aug. 5, 1997, 111 Stat. 433

(3) Update for 1999 and 2000

(A) In general

Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), the ''update adjustment factor'' for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) Determination of allowed expenditures

For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) Restriction on variation from medicare economic index

Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where ''MEI percentage'' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved.

(4) Update for years beginning with 2001 and ending with 2014

(A) In general

Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 and ending with 2014 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), subject to subparagraph (D) and the succeeding paragraphs of this subsection, the ''update adjustment factor'' for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) Prior year adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) Cumulative adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the

amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) Determination of allowed expenditures

For purposes of this paragraph:

(i) Period up to April 1, 1999

The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) Transition to calendar year allowed expenditures

Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) Years beginning with 2000

The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) Restriction on update adjustment factor

The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

(E) Recalculation of allowed expenditures for updates beginning with 2001

For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) Transitional adjustment designed to provide for budget neutrality

Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5) Update for 2004 and 2005

The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(6) Update for 2006

The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.

(7) Conversion factor for 2007

(A) In general

The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for 2007 (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

(B) No effect on computation of conversion factor for 2008

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.

(8) Update for 2008

(A) In general

Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for 2009

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2009 and subsequent years as if subparagraph (A) had never applied.

(9) Update for 2009

(A) In general

Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

(B) No effect on computation of conversion factor for 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.

(10) Update for January through May of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on January 1, 2010, and ending on May 31, 2010, the update to the single conversion factor shall be 0 percent for 2010.

(B) No effect on computation of conversion factor for remaining portion of 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph

(1)(A) for the period beginning on June 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied.

(11) Update for June through December of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), and (10)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on June 1, 2010, and ending on December 31, 2010, the update to the single conversion factor shall be 2.2 percent.

(B) No effect on computation of conversion factor for 2011 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

(12) Update for 2011

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

(B) No effect on computation of conversion factor for 2012 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.

(13) Update for 2012

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), and (12)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2012, the update to the single conversion factor shall be zero percent.

(B) No effect on computation of conversion factor for 2013 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.

(14) Update for 2013

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor for such year shall be zero percent.

(B) No effect on computation of conversion factor for 2014 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.

(15) Update for 2014

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2015 and subsequent years as if subparagraph (A) had never applied.

(16) Update for January through June of 2015

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) Update for July through December of 2015

The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(18) Update for 2016 through 2019

The update to the single conversion factor established in paragraph (1)(C)—

(A) for 2016 and each subsequent year through 2018 shall be 0.5 percent; and

(B) for 2019 shall be 0.25 percent.

(19) Update for 2020 through 2025

The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

(20) Update for 2026 and subsequent years

For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.

(e) Geographic adjustment factors

(1) Establishment of geographic indices

(A) In general

Subject to subparagraphs (B), (C), (E), (G), (H), and (I), the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) Class-specific geographic cost-of-practice indices

The Secretary may establish more than one index under subparagraph (A)(i) in the

case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) Periodic review and adjustments in geographic adjustment factors

The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elasped[2] since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) Use of recent data

In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E) Floor at 1.0 on work geographic index

After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2024, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(G)[3] Floor for practice expense, malpractice, and work geographic indices for services furnished in Alaska

For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5[1]

(H) Practice expense geographic adjustment for 2010 and subsequent years

(i) For 2010

Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) For 2011

Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) Hold harmless

The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) Analysis

The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) Revision for 2012 and subsequent years

As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office

[2] So in original. Probably should be ''elapsed''.

[3] So in original. No subpar. (F) has been enacted.

based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) Floor for practice expense index for services furnished in frontier States

(i) In general

Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1395ww(d)(3)(E)(iii)(II) of this title) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that[4] 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) Limitation

This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1395ww(d)(5)(H) of this title.

(2) Computation of geographic adjustment factor

For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) Geographic cost-of-practice adjustment factor

For purposes of paragraph (2), the ''geographic cost-of-practice adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) Geographic malpractice adjustment factor

For purposes of paragraph (2), the ''geographic malpractice adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) Geographic physician work adjustment factor

For purposes of paragraph (2), the ''geographic physician work adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(6) Use of MSAs as fee schedule areas in California

(A) In general

Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an ''MSA''), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) Transition for MSAs previously in rest-of-state payment locality or in locality 3

(i) In general

For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) Current law component

The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-based component

The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) Old weighting factor

The old weighting factor described in this clause—

(I) for 2017, is 5⁄6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1⁄6.

[4] So in original. Probably should be ''than''.

(iii) MSA-based weighting factor

The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) Hold harmless

For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) Transition area defined

In this paragraph, the term ''transition area'' means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) References to fee schedule areas

Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) Sustainable growth rate

(1) Publication

The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year through 2014 the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) Specification of growth rate

The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 and ending with 2014 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) Data to be used

For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) For 2001

For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) For 2002

For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) For 2003 and succeeding years

For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) Definitions

In this subsection:

(A) Services included in physicians' services

The term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) Medicare+Choice plan enrollee

The term ''Medicare+Choice plan enrollee'' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this subchapter for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1395mm of this title.

(C) Applicable period

The term ''applicable period'' means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

(g) Limitation on beneficiary liability

(1) Limitation on actual charges

(A) In general

In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) Application of limiting charge

No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) No liability for excess charges

No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) Correction of excess charges

If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) Refund of excess collections

If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) Sanctions

If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1395u(j) of this title. In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) Timely basis

For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided ''on a timely basis'', if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) "Limiting charge" defined

(A) For 1991

For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1395m(b) of this title, the ''limiting charge'' shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1395u(j)(1)(C) of this title as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting ''40 percent'' for ''25 percent''.

(B) For 1992

For physicians' services furnished during 1992, other than radiologist services subject to section 1395m(b) of this title, the ''limiting charge'' shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) After 1992

For physicians' services furnished in a year after 1992, the ''limiting charge'' shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) Recognized payment amount

In this section, the term ''recognized payment amount'' means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1395u(b)(4)(A)(iv) of this title) of the prevailing charge (or fee schedule amount)

for nonparticipating physicians for that year.

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX may only be made on an assignment-related basis and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section.

(B) Penalty

A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1395u(j)(2) of this title.

(4) Physician submission of claims

(A) In general

For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title)—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) Penalty

(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1395u(p)(3) of this title for a violation of section 1395u(p)(1) of this title.

(5) Electronic billing; direct deposit

The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) Monitoring of charges

(A) In general

The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) Report

The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) Plan

If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) Monitoring of utilization and access

(A) In general

The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) Report

The Secretary shall by not later than April 15,[5] of each year (beginning with 1991)

[5] So in original. The comma probably should not appear.

report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) Recommendations

The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) Sending information to physicians

Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1395u(h) of this title (relating to the participating physician program) for a year.

(i) Miscellaneous provisions

(1) Restriction on administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,

(D) the establishment of geographic adjustment factors under subsection (e),

(E) the establishment of the system for the coding of physicians' services under this section, and

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

(2) Assistants-at-surgery

(A) In general

Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) Denial of payment in certain cases

If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) No comparability adjustment

For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1395u(b)(3)(B) of this title on the basis that the payment amount is higher than the charge applicable, for comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1395u(b)(8) of this title, and

(C) section 1395u(b)(9) of this title shall not apply.

(j) Definitions

In this section:

(1) Category

For services furnished before January 1, 1998, the term ''category'' means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title), and all other physicians' services. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) Fee schedule area

Except as provided in subsection (e)(6)(D), the term ''fee schedule area'' means a locality used under section 1395u(b) of this title for purposes of computing payment amounts for physicians' services.

(3) Physicians' services

The term ''physicians' services'' includes items and services described in paragraphs (1),

(2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(*oo*)(2) of this title), (2)(R) (with respect to services described in subparagraphs (B), (C), and (D) of section 1395x(pp)(1) of this title), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1395x(nn)(2) of this title), and (15) of section 1395x(s) of this title (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(3), (g), and (h)[6] such other items and services as the Secretary may specify).

(4) Practice expenses

The term ''practice expenses'' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(k) Quality reporting system

(1) In general

The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) Use of consensus-based quality measures

(A) For 2007

(i) In general

For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of December 20, 2006, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

(ii) Subsequent refinements in application permitted

The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

(iii) Implementation

Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

(B) For 2008 and 2009

(i) In general

For purposes of reporting data on quality measures for covered professional services furnished during 2008 and 2009, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

(ii) Proposed set of measures

Not later than August 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable. The Secretary shall provide for a period of public comment on such set of measures.

(iii) Final set of measures

Not later than November 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable.

(C) For 2010 and subsequent years

(i) In general

Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(ii) Exception

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

[6] So in original. Probably should be followed by a comma.

(D) Opportunity to provide input on measures for 2009 and subsequent years

For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) Covered professional services and eligible professionals defined

For purposes of this subsection:

(A) Covered professional services

The term ''covered professional services'' means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

(B) Eligible professional

The term ''eligible professional'' means any of the following:

(i) A physician.

(ii) A practitioner described in section 1395u(b)(18)(C) of this title.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1395x(*ll*)(3)(B) of this title).

(4) Use of registry-based reporting

As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(5) Identification units

For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1395*l*(q)(1) of this title), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

(6) Education and outreach

The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) Implementation

The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

***(l)* Physician Assistance and Quality Initiative Fund**

(1) Establishment

The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the ''Fund'') which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

(2) Funding

(A) Amount available

(i) In general

Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) For expenditures during 2008, an amount equal to $150,500,000.

(II) For expenditures during 2009, an amount equal to $24,500,000.

(ii) Limitations on expenditures

(I) 2008

The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(II) 2009

The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

(B) Timely obligation of all available funds for services

The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) 2008 for payment with respect to physicians' services furnished during 2008; and

(ii) 2009 for payment with respect to physicians' services furnished during 2009.

(C) Payment from Trust Fund

The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(D) Funding limitation

Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(E) Construction

In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.

(m) Incentive payments for quality reporting

(1) Incentive payments

(A) In general

For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period; and

(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Applicable quality percent

For purposes of subparagraph (A), the term ''applicable quality percent'' means—

(i) for 2007 and 2008, 1.5 percent;
(ii) for 2009 and 2010, 2.0 percent;
(iii) for 2011, 1.0 percent; and
(iv) for 2012, 2013, and 2014, 0.5 percent.

(2) Incentive payments for electronic prescribing

(A) In general

Subject to subparagraph (D), for 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Limitation with respect to electronic prescribing quality measures

The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

(C) Applicable electronic prescribing percent

For purposes of subparagraph (A), the term ''applicable electronic prescribing percent'' means—

(i) for 2009 and 2010, 2.0 percent;
(ii) for 2011 and 2012, 1.0 percent; and
(iii) for 2013, 0.5 percent.

(D) Limitation with respect to EHR incentive payments

The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (*o*)(1)(A) with respect to a certified EHR technology (as defined in subsection (*o*)(4)) that has the capability of electronic prescribing.

(3) Satisfactory reporting and successful electronic prescriber described

(A) In general

For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

(i) Three or fewer quality measures applicable

If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(ii) Four or more quality measures applicable

If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.

(B) Successful electronic prescriber

(i) In general

For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

(ii) Requirement for submitting data on electronic prescribing quality measures

The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

(iii) Requirement for electronically prescribing under part D

The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

(iv) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

(v) Standards for electronic prescribing

To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1395w–104(e) of this title.

(C) Satisfactory reporting measures for group practices

(i) In general

By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year), or, for purposes of subsection (a)(8), for a quality reporting period for the year if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-

cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

(ii) Statistical sampling model

The process under clause (i) shall provide and, for 2016 and subsequent years, may provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1395cc–1 of this title.

(iii) No double payments

Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

(D) Satisfactory reporting measures through participation in a qualified clinical data registry

For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) and, for 2016 and subsequent years, subparagraph (A) or (C) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

(E) Qualified clinical data registry

(i) In general

The Secretary shall establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection.

(ii) Considerations

In establishing the requirements under clause (i), the Secretary shall consider whether an entity—

(I) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

(II) requires the submission of data from participants with respect to multiple payers;

(III) provides timely performance reports to participants at the individual participant level; and

(IV) supports quality improvement initiatives for participants.

(iii) Measures

With respect to measures used by a qualified clinical data registry—

(I) sections 1395aaa(b)(7) and 1395aaa–1(a) of this title shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title may be used.

(iv) Consultation

In carrying out this subparagraph, the Secretary shall consult with interested parties.

(v) Determination

The Secretary shall establish a process to determine whether or not an entity meets the requirements established under clause (i). Such process may involve one or both of the following:

(I) A determination by the Secretary.

(II) A designation by the Secretary of one or more independent organizations to make such determination.

(F) Authority to revise satisfactorily reporting data

For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).

(4) Form of payment

The payment under this subsection shall be in the form of a single consolidated payment.

(5) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other bonus payments

The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1395*l* of this title and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

(C) Implementation

Notwithstanding any other provision of law, for 2007, 2008, and 2009, the Secretary may implement by program instruction or otherwise this subsection.

(D) Validation

(i) In general

Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under this subsection for 2007 and 2008, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

(ii) Method

The Secretary may establish procedures to validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) Denial of payment authority

If the Secretary determines that an eligible professional (or, in the case of a

group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).

(E) Limitations on review

Except as provided in subparagraph (I), there shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of—

(i) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(ii) the determination of satisfactory reporting under this subsection;

(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(F) Extension

For 2008 through reporting periods occurring in 2015, the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

(H) Feedback

The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) Informal appeals process

The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

(6) Definitions

For purposes of this subsection:

(A) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(B) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(C) Reporting period

(i) In general

Subject to clauses (ii) and (iii), the term ''reporting period'' means—

(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

(II) for 2008 and subsequent years, the entire year.

(ii) Authority to revise reporting period

For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term ''reporting period'' shall mean such revised period.

(iii) Reference

Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) (a)(8)[7] shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii),[8] respectively.

(7) Integration of physician quality reporting and EHR reporting

Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (*o*) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (*o*); and

(ii) quality of care furnished to an individual.

(B) Such other activities as specified by the Secretary.

(8) Additional incentive payment

(A) In general

For 2011 through 2014, if an eligible professional meets the requirements described in

[7] So in original.

[8] So in original. Probably should be ''(a)(8)(C)(iii),''.

subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

(B) Requirements described

In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(C) Definitions

For purposes of this paragraph:

(i) The term ''Maintenance of Certification Program'' means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term ''qualified Maintenance of Certification Program practice assessment'' means an assessment of a physician's practice that—

(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(n) Physician Feedback Program

(1) Establishment

(A) In general

(i) Establishment

The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the ''Program'').

(ii) Reports on resources

The Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter.

(iii) Inclusion of certain information

If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.

(B) Resource use

The resources described in subparagraph (A)(ii) may be measured—

(i) on an episode basis;
(ii) on a per capita basis; or
(iii) on both an episode and a per capita basis.

(2) Implementation

The Secretary shall implement the Program by not later than January 1, 2009.

(3) Data for reports

To the extent practicable, reports under the Program shall be based on the most recent data available.

(4) Authority to focus initial application

The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(A) physician specialties that account for a certain percentage of all spending for physicians' services under this subchapter;

(B) physicians who treat conditions that have a high cost or a high volume, or both, under this subchapter;

(C) physicians who use a high amount of resources compared to other physicians;

(D) physicians practicing in certain geographic areas; or

(E) physicians who treat a minimum number of individuals under this subchapter.

(5) Authority to exclude certain information if insufficient information

The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

(6) Adjustment of data

To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(7) Education and outreach

The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

(8) Disclosure exemption

Reports under the Program shall be exempt from disclosure under section 552 of title 5.

(9) Reports on utilization

(A) Development of episode grouper

(i) In general

The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

(ii) Timeline for development

The episode grouper described in subparagraph (A)[9] shall be developed by not later than January 1, 2012.

(iii) Public availability

The Secretary shall make the details of the episode grouper described in subparagraph (A)[9] available to the public.

(iv) Endorsement

The Secretary shall seek endorsement of the episode grouper described in subparagraph (A)[9] by the entity with a contract under section 1395aaa(a) of this title.

(B) Reports on utilization

Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

(C) Analysis of data

The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

(i) attribute episodes of care, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

(D) Data adjustment

In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

(E) Public availability of methodology

The Secretary shall make available to the public—

(i) the methodologies established under subparagraph (C);

(ii) information regarding any adjustments made to data under subparagraph (D); and

(iii) aggregate reports with respect to physicians.

(F) Definition of physician

In this paragraph:

(i) In general

The term ''physician'' has the meaning given that term in section 1395x(r)(1) of this title.

(ii) Treatment of groups

Such term includes, as the Secretary determines appropriate, a group of physicians.

(G) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title,

[9] So in original. Probably means cl. (i) of this subpar.

section 1395*oo* of this title, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

(10) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(11) Reports ending with 2017

Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.

(*o*) Incentives for adoption and meaningful use of certified EHR technology

(1) Incentive payments

(A) In general

(i) In general

Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title), from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

(ii) No incentive payments with respect to years after 2016

No incentive payments may be made under this subsection with respect to a year after 2016.

(B) Limitations on amounts of incentive payments

(i) In general

In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

(ii) Amount

Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

(I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

(II) For the second payment year for such professional, $12,000.

(III) For the third payment year for such professional, $8,000.

(IV) For the fourth payment year for such professional, $4,000.

(V) For the fifth payment year for such professional, $2,000.

(VI) For any succeeding payment year for such professional, $0.

(iii) Phase down for eligible professionals first adopting EHR after 2013

If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

(iv) Increase for certain eligible professionals

In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 254e(a)(1)(A) of this title) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1395*l* of this title in a similar manner as such provisions apply under such subsection.

(v) No incentive payment if first adopting after 2014

If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

(C) Non-application to hospital-based eligible professionals

(i) In general

No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

(ii) Hospital-based eligible professional

For purposes of clause (i), the term ''hospital-based eligible professional'' means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination

of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) Payment

(i) Form of payment

The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) Coordination of application of limitation for professionals in different practices

In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) Coordination with Medicaid

The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XIX. The Secretary may also adjust the reporting periods under such subchapter and such subsections in order to carry out this clause.

(E) Payment year defined

(i) In general

For purposes of this subsection, the term ''payment year'' means a year beginning with 2011.

(ii) First, second, etc. payment year

The term ''first payment year'' means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms ''second payment year'', ''third payment year'', ''fourth payment year'', and ''fifth payment year'' mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

(2) Meaningful EHR user

(A) In general

An eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year) if each of the following requirements is met:

(i) Meaningful use of certified EHR technology

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

(ii) Information exchange

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) Limitation

The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph

(A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) Coordination of reporting of information

In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

(C) Demonstration of meaningful use of certified EHR technology and information exchange

(i) In general

A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of subparagraph (A).

(D) Continued application for purposes of MIPS

With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year. The provisions of subparagraphs (B) and (D) of subsection (a)(7),[5] shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).

(3) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other payments

The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1395*l*(m) of this title and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

(C) Limitations on review

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

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

(D) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

(4) Certified EHR technology defined

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

(5) Definitions

For purposes of this subsection:

(A) Covered professional services

The term ''covered professional services'' has the meaning given such term in subsection (k)(3).

(B) EHR reporting period

The term ''EHR reporting period'' means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(C) Eligible professional

The term ''eligible professional'' means a physician, as defined in section 1395x(r) of this title.

(p) Establishment of value-based payment modifier

(1) In general

The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) Quality

(A) In general

For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

(B) Measures

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1395aaa(a) of this title.

(C) Continued application for purposes of MIPS

The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) Costs

For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions)[10] and other factors determined appropriate by the Secretary. With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).

(4) Implementation

(A) Publication of measures, dates of implementation, performance period

Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(iii) The initial performance period (as specified under subparagraph (B)(ii)).

(B) Deadlines for implementation

(i) Initial implementation

Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

(ii) Initial performance period

(I) In general

The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

(II) Provision of information during initial performance period

During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

(iii) Application

The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.

(C) Budget neutrality

The payment modifier established under this subsection shall be implemented in a budget neutral manner.

(5) Systems-based care

The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) Consideration of special circumstances of certain providers

In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) Application

For purposes of the initial application of the payment modifier established under this subsection during the period beginning on Janu-

[10] So in original. Probably should be followed by a second closing parenthesis.

ary 1, 2015, and ending on December 31, 2016, the term ''physician'' has the meaning given such term in section 1395x(r) of this title. On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

(8) Definitions

For purposes of this subsection:

(A) Costs

The term ''costs'' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) Performance period

The term ''performance period'' means a period specified by the Secretary.

(9) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(10) Limitations on review

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

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

(D) the dates for implementation of the value-based payment modifier;

(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

(F) the application of the value-based payment modifier under paragraph (7); and

(G) the determination of costs under paragraph (8)(A).

(q) Merit-based Incentive Payment System

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the ''MIPS'') under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

(B) Program implementation

The MIPS shall apply to payments for covered professional services (as defined in subsection (k)(3)(A)) furnished on or after January 1, 2019.

(C) MIPS eligible professional defined

(i) In general

For purposes of this subsection, subject to clauses (ii) and (iv), the term ''MIPS eligible professional'' means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1395x(r) of this title), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title), and a group that includes such professionals; and

(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

(ii) Exclusions

For purposes of clause (i), the term ''MIPS eligible professional'' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title);

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) Partial qualifying APM participant

For purposes of this subparagraph, the term ''partial qualifying APM participant'' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1395*l*(z) of this title for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to each of 2021 through 2024—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph[7] were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2025 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph[7] were instead references to 50 percent and 20 percent, respectively.

(iv) Selection of low-volume threshold measurement

The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

(I) The minimum number (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, individuals enrolled under this part who are treated by the eligible professional for the performance period involved; and

(bb) for performance periods beginning on or after January 1, 2018, individuals enrolled under this part who are furnished covered professional services (as defined in subsection (k)(3)(A)) by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of covered professional services (as defined in subsection (k)(3)(A)) furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, allowed charges billed by such professional under this part for such performance period; and

(bb) for performance periods beginning on or after January 1, 2018, allowed charges for covered professional services (as defined in subsection (k)(3)(A)) billed by such professional for such performance period.

(v) Treatment of new Medicare enrolled eligible professionals

In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this subchapter such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

(vi) Clarification

In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

(vii) Partial qualifying APM participant clarifications

(I) Treatment as MIPS eligible professional

In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

(II) Not eligible for qualifying APM participant payments

In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1395*l*(z) of this title) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

(D) Application to group practices

(i) In general

Under the MIPS:

(I) Quality performance category

The Secretary shall establish and apply a process that includes features of

the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) Other performance categories

The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) Ensuring comprehensiveness of group practice assessment

The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

(E) Use of registries

Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) Application of certain provisions

In applying a provision of subsection (k), (m), (*o*), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(G) Accounting for risk factors

(i) Risk factors

Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

(2) Measures and activities under performance categories

(A) Performance categories

Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) Measures and activities specified for each category

For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) Quality

For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

(ii) Resource use

For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) Clinical practice improvement activities

For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms. This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(*o*) of this title. The Secretary

may establish this activity as a standalone or as a component of another activity.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1395*l*(z)(3)(C) of this title).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 254e(a)(1)(A) of this title).

(iv) Meaningful EHR use

For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (*o*)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) Additional provisions

(i) Emphasizing outcome measures under the quality performance category

In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) Application of additional system measures

The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

(iii) Global and population-based measures

The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) Application of measures and activities to non-patient-facing professionals

In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(v) Clinical practice improvement activities

(I) Request for information

In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(II) Contract authority for clinical practice improvement activities performance category

In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(aa) identifying activities described in subparagraph (B)(iii);

(bb) specifying criteria for such activities; and

(cc) determining whether a MIPS eligible professional meets such criteria.

(III) Clinical practice improvement activities defined

For purposes of this subsection, the term ''clinical practice improvement activity'' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) Annual list of quality measures available for MIPS assessment

(i) In general

Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

(bb) adding to such list, as appropriate, new quality measures; and

(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

(ii) Call for quality measures

(I) In general

Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1395aaa(a) of this title.

(II) Eligible professional organization defined

In this subparagraph, the term ''eligible professional organization'' means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(iv) Peer review

Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(v) Measures for inclusion

The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

(I) measures endorsed by a consensus-based entity;

(II) measures developed under subsection (s); and

(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(vi) Exception for qualified clinical data registry measures

Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(vii) Exception for existing quality measures

Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection beginning before the first performance period under the MIPS—

(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(viii) Consultation with relevant eligible professional organizations and other relevant stakeholders

Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

(ix) Optional application

The process under section 1395aaa–1 of this title is not required to apply to the selection of measures under this subparagraph.

(3) Performance standards

(A) Establishment

Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) Considerations in establishing standards

In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

(i) Historical performance standards.

(ii) Improvement.

(iii) The opportunity for continued improvement.

(4) Performance period

The Secretary shall establish a performance period (or periods) for a year (beginning with

2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) Composite performance score

(A) In general

Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the ''composite performance score'' for such professional for such performance period.

(B) Incentive to report; encouraging use of certified EHR technology for reporting quality measures

(i) Incentive to report

Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) Encouraging use of certified EHR technology and qualified clinical data registries for reporting quality measures

Under the methodology established under subparagraph (A), the Secretary shall—

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (*o*)(2)(A)(iii) for such year.

(C) Clinical practice improvement activities performance score

(i) Rule for certification

A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM participation

Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1395*l*(z)(3)(C) of this title) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

(iii) Subcategories

A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(D) Achievement and improvement

(i) Taking into account improvement

Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), subject to clause (iii), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) Assigning higher weight for achievement

Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(iii) Transition years

For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, the performance score for the performance category described in paragraph (2)(A)(ii) shall not take into account the improvement of the professional involved.

(E) Weights for the performance categories

(i) In general

Under the methodology developed under subparagraph (A), subject to subparagraph

(F)(i) and clause (ii), the composite performance score shall be determined as follows:

(I) Quality

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

(bb) First 5 years

For each of the first through fifth years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

(II) Resource use

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) First 5 years

For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.

(III) Clinical practice improvement activities

Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) Meaningful use of certified EHR technology

Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) Authority to adjust percentages in case of high EHR meaningful use adoption

In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (*o*)(5)) who are meaningful EHR users (as determined under subsection (*o*)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) Certain flexibility for weighting performance categories, measures, and activities

Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) Resource use

Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) Inclusion of quality measure data from other payers

In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) Use of voluntary virtual groups for certain assessment purposes

(i) In general

In the case of MIPS eligible professionals electing to be a virtual group under clause

(ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) Election of practices to be a virtual group

The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

The requirements for the process under clause (ii) shall—

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

(III) provide that a virtual group be a combination of tax identification numbers;

(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

(V) include such other requirements as the Secretary determines appropriate.

(6) MIPS payments

(A) MIPS adjustment factor

Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(iv) in a manner such that—

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(B) Applicable percent defined

For purposes of this paragraph, the term ''applicable percent'' means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(C) Additional MIPS adjustment factors for exceptional performance

For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(D) Establishment of performance thresholds

(i) Performance threshold

For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Subject to clauses (iii) and (iv), such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

(ii) Additional performance threshold for exceptional performance

In addition to the performance threshold under clause (i), for each year of the MIPS (beginning with 2019 and ending with 2024), the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, subject to clause (iii), the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

(iii) Special rule for initial 5 years

With respect to each of the first five years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

(I) be based on a period prior to such performance periods; and

(II) take into account—

(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

(bb) other factors determined appropriate by the Secretary.

(iv) Additional special rule for third, fourth and fifth years of MIPS

For purposes of determining MIPS adjustment factors under subparagraph (A), in addition to the requirements specified in clause (iii), the Secretary shall increase the performance threshold with respect to each of the third, fourth, and fifth years to which the MIPS applies to ensure a gradual and incremental transition to the performance threshold described in clause (i) (as estimated by the Secretary) with respect to the sixth year to which the MIPS applies.

(E) Application of MIPS adjustment factors

In the case of covered professional services (as defined in subsection (k)(3)(A)) furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such covered professional services and MIPS eligible professional for such year, shall be multiplied by—

(i) 1, plus

(ii) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) Aggregate application of MIPS adjustment factors

(i) Application of scaling factor

(I) In general

With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall in-

crease or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

(II) Scaling factor limit

In no case may the scaling factor applied under this clause exceed 3.0.

(ii) Budget neutrality requirement

(I) In general

Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

(II) Aggregate increases

The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

(III) Aggregate decreases

The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

(iii) Exceptions

(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

(iv) Additional incentive payment adjustments

(I) In general

Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) Limitation on additional incentive payment adjustments

The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

(7) Announcement of result of adjustments

Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for covered professional services (as defined in subsection (k)(3)(A)) furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

(8) No effect in subsequent years

The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

(9) Public reporting

(A) In general

The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models[11] (as defined in section 1395*l*(z)(3)(D) of this title) and, to the extent feasible, the names of such eligible alternative pay-

[11] So in original. Section 1395*l*(z)(3)(D) of this title defines the term ''eligible alternative payment entity''.

ment models and performance of such models.

(B) Disclosure

The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) Opportunity to review and submit corrections

The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) Aggregate information

The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

(10) Consultation

The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(11) Technical assistance to small practices and practices in health professional shortage areas

(A) In general

The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 300jj–32(c) of this title), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in[7] section 254e(a)(1)(A) of this title), and medically underserved areas, and practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1395*l*(z)(3)(C) of this title.

(B) Funding for technical assistance

For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(12) Feedback and information to improve performance

(A) Performance feedback

(i) In general

Beginning July 1, 2017, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) Mechanisms

The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as[12] described in subsection (m)(3)(E)).

(iii) Use of data

For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) Disclosure exemption

Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5.

(v) Receipt of information

The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

[12] So in original. Probably should be preceded by an opening parenthesis.

(B) Additional information

(i) In general

Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this subchapter that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1395jjj of this title.

(ii) Type of information

For purposes of clause (i), the information described in this clause,[5] is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this subchapter and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

(13) Review

(A) Targeted review

The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

(B) Limitation

Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement

(1) In general

In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1395*l*(z) of this title, the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) Development of care episode and patient condition groups and classification codes

(A) In general

In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Public availability of existing efforts to design an episode grouper

Not later than 180 days after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) Stakeholder input

The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) care episode groups; and
(ii) patient condition groups.

(D) Development of proposed classification codes

(i) In general

Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

(II) assign codes to such groups.

(ii) Care episode groups

In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) Patient condition groups

In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this subchapter (including eligibility under section 426(a) of this title, section 426(b) of this title, or section 426–1 of this title, and dual eligibility under this subchapter and subchapter XIX).

(E) Draft care episode and patient condition groups and classification codes

Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) Solicitation of input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) Operational list of care episode and patient condition groups and codes

Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(I) Information

The Secretary shall, not later than December 31st of each year (beginning with 2018), post on the Internet website of the Centers for Medicare & Medicaid Services information on resource use measures in use under subsection (q), resource use measures under development and the time-frame for such development, potential future resource use measure topics, a description of stakeholder engagement, and the percent of expenditures under part A and this part that are covered by resource use measures.

(3) Attribution of patients to physicians or practitioners

(A) In general

In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Development of patient relationship categories and codes

The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes

may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) Draft list of patient relationship categories and codes

Not later than one year after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) Stakeholder input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) Operational list of patient relationship categories and codes

Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) Reporting of information for resource use measurement

Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) Methodology for resource use analysis

(A) In general

In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) Analysis of patients of physicians and practitioners

In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) Measurement of resource use

In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as

subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) Stakeholder input

The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) Implementation

To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

(7) Limitation

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

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(8) Administration

Chapter 35 of title 44 shall not apply to this section.

(9) Definitions

In this subsection:

(A) Physician

The term ''physician'' has the meaning given such term in section 1395x(r)(1) of this title.

(B) Applicable practitioner

The term ''applicable practitioner'' means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), and a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title); and

(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(10) Clarification

The provisions of sections 1395aaa(b)(7) of this title and 1395aaa–1 of this title shall not apply to this subsection.

(s) Priorities and funding for measure development

(1) Plan identifying measure development priorities and timelines

(A) Draft measure development plan

Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) address how measures used by private payers and integrated delivery systems could be incorporated under subchapter XVIII;

(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

(B) Quality domains

For purposes of this subsection, the term ''quality domains'' means at least the following domains:

(i) Clinical care.

(ii) Safety.

(iii) Care coordination.

(iv) Patient and caregiver experience.

(v) Population health and prevention.

(C) Consideration

In developing the draft plan under this paragraph, the Secretary shall consider—

(i) gap analyses conducted by the entity with a contract under section 1395aaa(a) of this title or other contractors or entities;

(ii) whether measures are applicable across health care settings;

(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

(iv) the quality domains applied under this subsection.

(D) Priorities

In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

(i) Outcome measures, including patient reported outcome and functional status measures.

(ii) Patient experience measures.

(iii) Care coordination measures.

(iv) Measures of appropriate use of services, including measures of over use.

(E) Stakeholder input

The Secretary shall accept through March 1, 2016, comments on the draft plan posted

under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(F) Final measure development plan

Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

(2) Contracts and other arrangements for quality measure development

(A) In general

The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

(B) Prioritization

(i) In general

In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

(ii) Consideration

In selecting measures for development under this subsection, the Secretary shall consider—

(I) whether such measures would be electronically specified; and

(II) clinical practice guidelines to the extent that such guidelines exist.

(3) Annual report by the Secretary

(A) In general

Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) Requirements

Each report submitted pursuant to subparagraph (A) shall include the following:

(i) A description of the Secretary's efforts to implement this paragraph.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this subchapter to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(v) Other information the Secretary determines to be appropriate.

(4) Stakeholder input

With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) Definition of applicable provisions

In this subsection, the term ''applicable provisions'' means the following provisions:

(A) Subsection (q)(2)(B)(i).

(B) section[13] 1395*l*(z)(3)(D) of this title.

(6) Funding

For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

(7) Administration

Chapter 35 of title 44 shall not apply to the collection of information for the development of quality measures.

(t) Supporting physicians and other professionals in adjusting to Medicare payment changes during 2021 and 2022

(1) In general

In order to support physicians and other professionals in adjusting to changes in payment for physicians' services during 2021 and 2022, the Secretary shall increase fee schedules under subsection (b) that establish payment amounts for—

(A) such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent; and

(B) such services furnished on or after January 1, 2022, and before January 1, 2023, by 3.0 percent.

[13] So in original. Probably should be ''Section''.

(2) Implementation

(A) Administration

Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise.

(B) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title[6] or otherwise of the fee schedules that establish payment amounts calculated pursuant to this subsection.

(C) Application only for 2021 and 2022

The increase in fee schedules that establish payment amounts under this subsection for services furnished in 2021 or 2022 shall not be taken into account in determining such fee schedules that establish payment amounts for services furnished in years after 2021 or 2022, respectively.

(3) Funding

For purposes of increasing the fee schedules that establish payment amounts pursuant to this subsection—

(A) there shall be transferred from the General Fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, $3,000,000,000, to remain available until expended; and

(B) in the event the Secretary determines additional amounts are necessary, such amounts shall be available from the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XVIII, § 1848, as added Pub. L. 101–239, title VI, § 6102(a), Dec. 19, 1989, 103 Stat. 2169; amended Pub. L. 101–508, title IV, §§ 4102(b), (g)(2), 4104(b)(2), 4105(a)(3), (c), 4106(b)(1), 4107(a)(1), 4109(a), 4116, 4118(b)–(f)(1), (k), Nov. 5, 1990, 104 Stat. 1388–56, 1388–57, 1388–59 to 1388–63, 1388–65, 1388–67, 1388–68, 1388–71; Pub. L. 103–66, title XIII, §§ 13511(a), 13512–13514(c), 13515(a)(1), (c), 13516(a)(1), 13517(a), 13518(a), Aug. 10, 1993, 107 Stat. 580–583, 585, 586; Pub. L. 103–432, title I, §§ 121(b)(1), (2), 122(a), (b), 123(a), (d), 126(b)(6), (g)(2)(B), (5)–(7), (10)(A), Oct. 31, 1994, 108 Stat. 4409, 4410, 4412, 4415, 4416; Pub. L. 105–33, title IV, §§ 4022(b)(2)(B), (C), 4102(d), 4103(d), 4104(d), 4105(a)(2), 4106(b), 4501, 4502(a)(1), (b), 4503, 4504(a), 4505(a), (b), (e), (f)(1), 4644(d), 4714(b)(2), Aug. 5, 1997, 111 Stat. 354, 355, 361, 362, 365, 366, 368, 432–437, 488, 510; Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 211(a)(1), (2)(A), (3)(A), (b), title III, § 321(k)(5)], Nov. 29, 1999, 113 Stat. 1536, 1501A–345 to 1501A–348, 1501A–366; Pub. L. 106–554, § 1(a)(6) [title I, § 104(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–469; Pub. L. 108–7, div. N, title IV, § 402(a), Feb. 20, 2003, 117 Stat. 548; Pub. L. 108–173, title III, § 303(a)(1), (g)(2), title IV, § 412, title VI, §§ 601(a)(1), (2), (b)(1), 602, 611(c), title VII, § 736(b)(10), Dec. 8, 2003, 117 Stat. 2233, 2253, 2274, 2300, 2301, 2304, 2356; Pub. L. 109–171, title V, §§ 5102, 5104(a), 5112(c), Feb. 8, 2006, 120 Stat. 39, 40, 44; Pub. L. 109–432, div. B, title I, §§ 101(a), (b), (d), 102, Dec. 20, 2006, 120 Stat. 2975, 2980, 2981; Pub. L. 110–90, § 6, Sept. 29, 2007, 121 Stat. 985; Pub. L. 110–161, div. G, title II, § 225(c)(2), title V, § 524, Dec. 26, 2007, 121 Stat. 2190, 2212; Pub. L. 110–173, title I, §§ 101(a)(1), (2)(A), (b)(1), 103, Dec. 29, 2007, 121 Stat. 2493–2495; Pub. L. 110–252, title VII, § 7002(c), June 30, 2008, 122 Stat. 2395; Pub. L. 110–275, title I, §§ 131(a)(1), (3)(C), (b)(1)–(4)(A), (5), (c)(1), 132(a), (b), 133(b), 134, 139(a), 144(a)(2), 152(b)(1)(C), July 15, 2008, 122 Stat. 2520–2522, 2525–2527, 2529, 2532, 2541, 2546, 2552; Pub. L. 111–5, div. B, title IV, § 4101(a), (b), (f), Feb. 17, 2009, 123 Stat. 467, 472, 476; Pub. L. 111–118, div. B, § 1011(a), Dec. 19, 2009, 123 Stat. 3473; Pub. L. 111–144, § 5, Mar. 2, 2010, 124 Stat. 46; Pub. L. 111–148, title III, §§ 3002(a)–(c)(1), (d)–(f), 3003(a), 3007, 3101, 3102, 3111(a)(1), 3134(a), 3135(a), (b), title IV, § 4103(c)(2), title V, § 5501(c), title X, §§ 10310, 10324(c), 10327(a), 10501(h), Mar. 23, 2010, 124 Stat. 363–366, 373, 415, 416, 421, 434, 436, 437, 556, 654, 942, 960, 962, 997; Pub. L. 111–152, title I, §§ 1107, 1108, Mar. 30, 2010, 124 Stat. 1050; Pub. L. 111–157, §§ 4, 5(a)(1), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111–192, title I, § 101(a), June 25, 2010, 124 Stat. 1280; Pub. L. 111–286, §§ 2, 3, Nov. 30, 2010, 124 Stat. 3056; Pub. L. 111–309, title I, §§ 101, 103, Dec. 15, 2010, 124 Stat. 3285, 3287; Pub. L. 112–78, title III, §§ 301, 303, 309, Dec. 23, 2011, 125 Stat. 1283, 1284, 1286; Pub. L. 112–96, title III, §§ 3003(a), 3004(a), Feb. 22, 2012, 126 Stat. 186, 187; Pub. L. 112–240, title VI, §§ 601(a), (b)(1), 602, 633(a), 635, Jan. 2, 2013, 126 Stat. 2345, 2347, 2355, 2356; Pub. L. 113–67, div. B, title I, §§ 1101, 1102, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, §§ 101, 102, title II, §§ 218(a)(2)(B), 220(a)–(f), (h), Apr. 1, 2014, 128 Stat. 1041, 1064, 1070–1074; Pub. L. 113–295, div. B, title II, § 202, Dec. 19, 2014, 128 Stat. 4065; Pub. L. 114–10, title I, §§ 101(a)(1), (2), (b), (c)(1), (d), (f), 102, 103(a), 106(b)(2)(A), title II, § 201, title V, § 523, Apr. 16, 2015, 129 Stat. 89, 91, 92, 115, 123–131, 139, 143, 177; Pub. L. 114–113, div. O, title V, § 502(a)(1)–(2)(B), Dec. 18, 2015, 129 Stat. 3018, 3019; Pub. L. 114–115, §§ 3(a), 4(a), Dec. 28, 2015, 129 Stat. 3132, 3133; Pub. L. 114–255, div. A, title IV, § 4002(b)(1), div. C, title XVI, § 16003, Dec. 13, 2016, 130 Stat. 1161, 1326; Pub. L. 115–123, div. E, title II, § 50201, title IV, § 50413, title X, §§ 51003(a), 51009, title XII, § 53106, Feb. 9, 2018, 132 Stat. 176, 221, 293, 297, 303; Pub. L. 116–94, div. N, title I, § 101, Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, § 3801, Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–159, div. C, title II, § 2201, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, § 1101, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. N, title I, § 101(a), (b), div. CC, title I, §§ 101, 114(b), 119(c), Dec. 27, 2020, 134 Stat. 1949, 1950, 2940, 2948, 2953; Pub. L. 117–71, § 3(a), Dec. 10, 2021, 135 Stat. 1507.)

Editorial Notes

REFERENCES IN TEXT

Section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsecs. (a)(2)(B)(ii)(I), (c)(2)(A)(i), and (i)(1)(B), is section 13515(b) of Pub. L. 103–66, which is set out as a note under section 1395u of this title.

Section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (a)(2)(D)(ii), (iii), is section 6105(b) of Pub. L. 101–239, which is set out as a note under section 1395m of this title.

Section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (b)(2)(B), is section 4048(b) of Pub. L. 100–203, which is set out as a note under section 1395u of this title.

Section 13514(a) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (c)(2)(F), is sec-

tion 13514(a) of Pub. L. 103–66, which amended subsec. (b)(3) of this section. See 1993 Amendment note below.

Section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (c)(2)(H)(i), (I)(ii)(I), is section 1000(a)(6) [title II, § 212] of Pub. L. 106–113, which is set out as a note under this section.

The Balanced Budget Act of 1997, referred to in subsec. (d)(1)(C), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. Chapter 1 of subtitle F of title IV of the Act is chapter 1 (§§ 4501–4513) of subtitle F of title IV of Pub. L. 105–33, which amended this section and sections 1395a, 1395k, 1395*l*, 1395u, 1395x, 1395y, 1395cc, and 1395yy of this title and enacted provisions set out as notes under this section and sections 1395a, 1395k, 1395*l*, 1395x, and 1395ww of this title. For complete classification of this Act to the Code, see Tables.

Section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008, referred to in subsec. (*l*)(2)(A)(ii)(I), (II), are sections 225(c)(1) of title II and 524 of title V of div. G of Pub. L. 110–161, Dec. 26, 2007, 121 Stat. 2190, 2212. Section 225(c)(1) is not classified to the Code and section 524 amended this section.

Section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, referred to in subsec. (q)(1)(G)(i), is section 2(d) of Pub. L. 113–185, which is set out as a note under section 1395*lll* of this title.

CODIFICATION

The text of section 101(c) of Pub. L. 109–432, div. B, title I, Dec. 20, 2006, 120 Stat. 2977, as amended by Pub. L. 110–173, title I, § 101(b)(2), Dec. 29, 2007, 121 Stat. 2494, which was formerly set out as a note under this section, was transferred to subsec. (m) of this section and amended by Pub. L. 110–275.

AMENDMENTS

2021—Subsec. (c)(2)(B)(iv)(V). Pub. L. 117–71, § 3(a)(1), substituted ''2021 or 2022'' for ''2021''.

Subsec. (t). Pub. L. 117–71, § 3(a)(2)(A), substituted ''2021 and 2022'' for ''2021'' in heading.

Subsec. (t)(1). Pub. L. 117–71, § 3(a)(2)(B), substituted ''during 2021 and 2022'' for ''during 2021'' and ''payment amounts for—'' and subpars. (A) and (B) for ''payment amounts for such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent.''

Subsec. (t)(2)(C). Pub. L. 117–71, § 3(a)(2)(C), substituted ''2021 and 2022'' for ''2021'' in heading and, in text, inserted ''for services furnished in 2021 or 2022'' after ''under this subsection'' and ''or 2022, respectively'' before period at end.

2020—Subsec. (c)(2)(B)(iv)(V). Pub. L. 116–260, § 101(b), added subcl. (V).

Subsec. (e)(1)(E). Pub. L. 116–260 substituted ''January 1, 2024'' for ''December 19, 2020''.

Pub. L. 116–215 substituted ''December 19, 2020'' for ''December 12, 2020''.

Pub. L. 116–159 substituted ''December 12, 2020'' for ''December 1, 2020''.

Pub. L. 116–136 substituted ''December 1, 2020'' for ''May 23, 2020''.

Subsec. (q)(1)(C)(iii)(II). Pub. L. 116–260, § 114(b)(1), substituted ''each of 2021 through 2024'' for ''2021 and 2022'' in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 116–260, § 114(b)(2), substituted ''2025'' for ''2023'' in introductory provisions.

Subsec. (q)(2)(B)(iii)(IV). Pub. L. 116–260, § 119(c), inserted at end ''This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(*o*) of this title. The Secretary may establish this activity as a standalone or as a component of another activity.''

Subsec. (t). Pub. L. 116–260, § 101(a), added subsec. (t).

2019—Subsec. (e)(1)(E). Pub. L. 116–94 substituted ''May 23, 2020'' for ''January 1, 2020''.

2018—Subsec. (b)(11). Pub. L. 115–123, § 51009(1), substituted ''2017, 2018, and 2019'' for ''2017 and 2018''.

Subsec. (c)(2)(K)(iv). Pub. L. 115–123, § 51009(2), substituted ''2017, 2018, and 2019'' for ''2017 and 2018''.

Subsec. (d)(18). Pub. L. 115–123, § 53106, substituted ''paragraph (1)(C)—'' for ''paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.'' and added subpars. (A) and (B).

Subsec. (e)(1)(E). Pub. L. 115–123, § 50201, substituted ''January 1, 2020'' for ''January 1, 2018''.

Subsec. (*o*)(2)(A). Pub. L. 115–123, § 50413, struck out ''by requiring more stringent measures of meaningful use selected under this paragraph'' after ''health care quality over time'' in concluding provisions.

Subsec. (q)(1)(B). Pub. L. 115–123, § 51003(a)(1)(A)(i), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (q)(1)(C)(iv)(I). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(I), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: ''The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.''

Subsec. (q)(1)(C)(iv)(II). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(II), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (q)(1)(C)(iv)(III). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(III), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: ''The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.''

Subsec. (q)(5)(D)(i)(I). Pub. L. 115–123, § 51003(a)(1)(B)(i), inserted ''subject to clause (iii),'' after ''clauses (i) and (ii) of paragraph (2)(A),''.

Subsec. (q)(5)(D)(iii). Pub. L. 115–123, § 51003(a)(1)(B)(ii), added cl. (iii).

Subsec. (q)(5)(E)(i)(I)(bb). Pub. L. 115–123, § 51003(a)(1)(C)(i), substituted ''First 5 years'' for ''First 2 years'' in heading and ''each of the first through fifth years'' for ''the first and second years'' in text.

Subsec. (q)(5)(E)(i)(II)(bb). Pub. L. 115–123, § 51003(a)(1)(C)(ii), substituted ''5 years'' for ''2 years'' in heading and ''For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.'' for ''For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).'' in text.

Subsec. (q)(6)(D)(i). Pub. L. 115–123, § 51003(a)(1)(D)(i), substituted ''Subject to clauses (iii) and (iv), such performance threshold'' for ''Such performance threshold''.

Subsec. (q)(6)(D)(ii). Pub. L. 115–123, § 51003(a)(1)(D)(ii), in introductory provisions, inserted ''(beginning with 2019 and ending with 2024)'' after ''for each year of the MIPS'' and ''subject to clause (iii),'' after ''For each such year,''.

Subsec. (q)(6)(D)(iii). Pub. L. 115–123, § 51003(a)(1)(D)(iii), substituted ''5'' for ''2'' in heading and ''five years'' for ''two years'' in introductory provisions.

Subsec. (q)(6)(D)(iv). Pub. L. 115–123, § 51003(a)(1)(D)(iv), added cl. (iv).

Subsec. (q)(6)(E). Pub. L. 115–123, § 51003(a)(1)(E), in introductory provisions, substituted ''In the case of covered professional services (as defined in subsection (k)(3)(A))'' for ''In the case of items and services'' and ''under this part with respect to such covered professional services'' for ''under this part with respect to such items and services''.

Subsec. (q)(7). Pub. L. 115–123, § 51003(a)(1)(F), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (r)(2)(I). Pub. L. 115–123, § 51003(a)(2), added subpar. (I).

Subsec. (s)(5)(B). Pub. L. 115–123, § 51003(a)(3), which directed amendment of subpar. (B) by substituting ''section 1395*l*(z)(3)(D)'' for ''section 1395*l*(z)(2)(C)'', was executed by making the substitution for ''Section 1395*l*(z)(2)(C)'' to reflect the probable intent of Congress.

2016—Subsec. (a)(7)(B). Pub. L. 114–255, § 4002(b)(1)(A), inserted after first sentence ''The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title.''

Subsec. (a)(7)(D). Pub. L. 114–255, § 16003, substituted ''hospital-based and ambulatory surgical center-based eligible professionals'' for ''hospital-based eligible professionals'' in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cls. (ii) to (iv).

Subsec. (*o*)(2)(D). Pub. L. 114–255, § 4002(b)(1)(B), inserted at end ''The provisions of subparagraphs (B) and (D) of subsection (a)(7), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).''

2015—Subsec. (a)(7)(A)(i). Pub. L. 114–10, § 101(b)(1)(A)(i), substituted ''each of 2015 through 2018'' for ''2015 or any subsequent payment year''.

Subsec. (a)(7)(A)(ii)(III). Pub. L. 114–10, § 101(b)(1)(A)(ii), substituted ''2018'' for ''each subsequent year''.

Subsec. (a)(7)(A)(iii). Pub. L. 114–10, § 101(b)(1)(A)(iii), struck out ''and subsequent years'' after ''for 2018'' in heading and ''and each subsequent year'' after ''For 2018'' and '', but in no case shall the applicable percent be less than 95 percent'' after ''in the preceding year'' in text.

Subsec. (a)(7)(B). Pub. L. 114–115, § 4(a), inserted ''(and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016)'' after ''case-by-case basis''.

Subsec. (a)(8)(A)(i). Pub. L. 114–10, § 101(b)(2)(A)(i), substituted ''each of 2015 through 2018'' for ''2015 or any subsequent year''.

Subsec. (a)(8)(A)(ii)(II). Pub. L. 114–10, § 101(b)(2)(A)(ii), substituted '', 2017, and 2018'' for ''and each subsequent year''.

Subsec. (a)(9). Pub. L. 114–10, § 523(b), added par. (9).

Subsec. (b)(8). Pub. L. 114–10, § 103(a), added par. (8).

Subsec. (b)(9). Pub. L. 114–113, § 502(a)(1)(A), added par. (9).

Subsec. (b)(10). Pub. L. 114–113, § 502(a)(2)(A), added par. (10).

Subsec. (b)(11). Pub. L. 114–115, § 3(a)(1), added par. (11).

Subsec. (c)(2)(B)(v)(X). Pub. L. 114–113, § 502(a)(1)(B), added subcl. (X).

Subsec. (c)(2)(B)(v)(XI). Pub. L. 114–113, § 502(a)(2)(B), added subcl. (XI).

Subsec. (c)(2)(K)(iv). Pub. L. 114–115, § 3(a)(2), added cl. (iv).

Subsec. (c)(8). Pub. L. 114–10, § 523(a), added par. (8).

Subsec. (d)(1)(A). Pub. L. 114–10, § 101(a)(1)(A)(i), (2)(A), inserted ''and ending with 2025'' after ''beginning with 2001'', ''or a subsequent paragraph'' after ''paragraph (4)'', and ''There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title) (referred to in this subsection as the 'qualifying APM conversion factor') and the other for other items and services (referred to in this subsection as the 'nonqualifying APM conversion factor'), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.'' at end.

Subsec. (d)(1)(D). Pub. L. 114–10, § 101(a)(2)(B), inserted ''(or, beginning with 2026, applicable conversion factor)'' after ''single conversion factor''.

Subsec. (d)(4). Pub. L. 114–10, § 101(a)(1)(A)(ii)(I), inserted ''and ending with 2014'' after ''years beginning with 2001'' in heading.

Subsec. (d)(4)(A). Pub. L. 114–10, § 101(a)(1)(A)(ii)(II), inserted ''and ending with 2014'' after ''a year beginning with 2001'' in introductory provisions.

Subsec. (d)(16) to (20). Pub. L. 114–10, § 101(a)(2)(C), added pars. (16) to (20) and struck out former par. (16) which related to update for January through March of 2015.

Subsec. (e)(1)(E). Pub. L. 114–10, § 201, substituted ''January 1, 2018'' for ''April 1, 2015''.

Subsec. (f)(1)(B). Pub. L. 114–10, § 101(a)(1)(B)(i), inserted ''through 2014'' after ''of each succeeding year''.

Subsec. (f)(2). Pub. L. 114–10, § 101(a)(1)(B)(ii), inserted ''and ending with 2014'' after ''beginning with 2000'' in introductory provisions.

Subsec. (k)(9). Pub. L. 114–10, § 101(b)(2)(B)(i), added par. (9).

Subsec. (m)(3)(C)(ii). Pub. L. 114–10, § 101(d)(1)(A), inserted ''and, for 2016 and subsequent years, may provide'' after ''shall provide''.

Subsec. (m)(3)(D). Pub. L. 114–10, § 101(d)(1)(B), inserted ''and, for 2016 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

Subsec. (m)(5)(F). Pub. L. 114–10, § 101(d)(2), substituted ''through reporting periods occurring in 2015'' for ''and subsequent years'' and inserted ''and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish'' after ''shall establish''.

Subsec. (m)(7) to (9). Pub. L. 114–10, § 101(b)(2)(B)(ii), redesignated par. (7) relating to additional incentive payment as (8) and added par. (9).

Subsec. (n)(11). Pub. L. 114–10, § 101(d)(3), added par. (11).

Subsec. (*o*)(2)(A). Pub. L. 114–10, § 101(b)(1)(B)(i), in introductory provisions, substituted ''An'' for ''For purposes of paragraph (1), an'' and inserted '', or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''.

Subsec. (*o*)(2)(A)(ii). Pub. L. 114–10, § 106(b)(2)(A), inserted '', and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology'' before period at end.

Subsec. (*o*)(2)(A)(iii). Pub. L. 114–10, § 101(d)(4), inserted ''and subsection (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

Subsec. (*o*)(2)(D). Pub. L. 114–10, § 101(b)(1)(B)(ii), added subpar. (D).

Subsec. (p)(2)(C). Pub. L. 114–10, § 101(b)(3)(B)(i), added subpar. (C).

Subsec. (p)(3). Pub. L. 114–10, § 101(b)(3)(B)(ii), inserted at end ''With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).''

Subsec. (p)(4)(B)(iii). Pub. L. 114–10, § 101(b)(3)(A), amended cl. (iii) generally. Prior to amendment, text read as follows: ''The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

''(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

''(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.''

Subsec. (q). Pub. L. 114–10, § 101(c)(1), added subsec. (q).

Subsec. (r). Pub. L. 114–10, § 101(f), added subsec. (r).

Subsec. (s). Pub. L. 114–10, § 102, added subsec. (s).

2014—Subsec. (c)(2)(B)(ii)(I). Pub. L. 113–93, § 220(e)(2)(A), substituted ''subclause (II) and paragraph (7)'' for ''subclause (II)''.

Subsec. (c)(2)(B)(v)(VIII). Pub. L. 113–295, § 202(1)(A), substituted ''2016'' for ''2017'' in subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, § 220(d)(2), added subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, § 218(a)(2)(B), added subcl. (VIII) relating to reduced expenditures attributable to application of quality incentives for computed tomography.

Subsec. (c)(2)(B)(v)(IX). Pub. L. 113–295, § 202(1)(B), redesignated subcl. (VIII) relating to reductions for misvalued services if target not met as (IX).

Subsec. (c)(2)(C)(i). Pub. L. 113–93, § 220(f)(1), substituted ''the service or group of services'' for ''the service'' in two places.

Subsec. (c)(2)(C)(ii). Pub. L. 113–93, § 220(f)(2), inserted ''or group of services'' after ''furnishing the service'' the first time appearing in concluding provisions.

Subsec. (c)(2)(C)(iii). Pub. L. 113–93, § 220(f)(1), substituted ''the service or group of services'' for ''the service'' wherever appearing.

Subsec. (c)(2)(K)(ii). Pub. L. 113–93, § 220(c), amended cl. (ii) generally. Prior to amendment, text read as follows: ''For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.''

Subsec. (c)(2)(K)(iii)(VI). Pub. L. 113–93, § 220(e)(2)(B), substituted ''provisions of subparagraph (B)(ii)(II) and paragraph (7)'' for ''provisions of subparagraph (B)(ii)(II)'' and ''under subparagraph (B)(ii)(I)'' for ''under subparagraph (B)(ii)(II)''.

Subsec. (c)(2)(M). Pub. L. 113–93, § 220(a)(1), added subpar. (M).

Subsec. (c)(2)(N). Pub. L. 113–93, § 220(b), added subpar. (N).

Subsec. (c)(2)(O). Pub. L. 113–295, § 202(2)(A), substituted ''2016 through 2018'' for ''2017 through 2020'' in introductory provisions.

Pub. L. 113–93, § 220(d)(1), added subpar. (O).

Subsec. (c)(2)(O)(iii). Pub. L. 113–295, § 202(2)(B), substituted ''2016'' for ''2017''.

Subsec. (c)(2)(O)(v). Pub. L. 113–295, § 202(2)(C), inserted ''(or, for 2016, 1.0 percent)'' after ''0.5 percent''.

Subsec. (c)(7). Pub. L. 113–295, § 202(3), substituted ''2016'' for ''2017''.

Pub. L. 113–93, § 220(e)(1), added par. (7).

Subsec. (d)(15). Pub. L. 113–93, § 101(1)(A), struck out ''January through March of'' before ''2014'' in heading.

Subsec. (d)(15)(A). Pub. L. 113–93, § 101(1)(B), struck out ''for the period beginning on January 1, 2014, and ending on March 31, 2014'' after ''2014''.

Subsec. (d)(15)(B). Pub. L. 113–93, § 101(1)(C), struck out ''remaining portion of 2014 and'' before ''subsequent years'' in heading and ''the period beginning on April 1, 2014, and ending on December 31, 2014, and for'' before ''2015'' in text.

Subsec. (d)(16). Pub. L. 113–93, § 101(2), added par. (16).

Subsec. (e)(1)(E). Pub. L. 113–93, § 102, substituted ''April 1, 2015'' for ''April 1, 2014''.

Subsec. (e)(6). Pub. L. 113–93, § 220(h)(1), added par. (6).

Subsec. (i)(1)(F). Pub. L. 113–93, § 220(a)(2), added subpar. (F).

Subsec. (j)(2). Pub. L. 113–93, § 220(h)(2), substituted ''Except as provided in subsection (e)(6)(D), the term'' for ''The term''.

2013—Subsec. (b)(4)(C). Pub. L. 112–240, § 635(1), substituted '', 2012, and 2013'' for ''and subsequent years'' and inserted at end ''With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.''

Subsec. (b)(7). Pub. L. 112–240, § 633(a), substituted ''2011, and before April 1, 2013,'' for ''2011,'' and inserted at end ''In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.''

Subsec. (c)(2)(B)(v)(III). Pub. L. 112–240, § 635(2), substituted ''changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of'' for ''change in the utilization rate applicable to 2011, as described in''.

Subsec. (d)(14). Pub. L. 112–240, § 601(a), added par. (14).

Subsec. (d)(15). Pub. L. 113–67, § 1101, added par. (15).

Subsec. (e)(1)(E). Pub. L. 113–67, § 1102, substituted ''April 1, 2014'' for ''January 1, 2014''.

Pub. L. 112–240, § 602, substituted ''before January 1, 2014'' for ''before January 1, 2013''.

Subsec. (m)(3)(D) to (F). Pub. L. 112–240, § 601(b)(1), added subpars. (D) and (E) and redesignated former subpar. (D) as (F).

2012—Subsec. (d)(13). Pub. L. 112–96, § 3003(a)(1), substituted ''2012'' for ''first two months of 2012'' in heading.

Subsec. (d)(13)(A). Pub. L. 112–96, § 3003(a)(2), substituted ''2012'' for ''the period beginning on January 1, 2012, and ending on February 29, 2012''.

Subsec. (d)(13)(B). Pub. L. 112–96, § 3003(a)(3), (4), substituted ''2013'' for ''remaining portion of 2012'' in heading and ''for 2013'' for ''for the period beginning on March 1, 2012, and ending on December 31, 2012, and for 2013'' in text.

Subsec. (e)(1)(E). Pub. L. 112–96, § 3004(a), substituted ''before January 1, 2013'' for ''before March 1, 2012''.

2011—Subsec. (b)(4)(B), (6). Pub. L. 112–78, § 309(1), substituted '', 2011, and the first 2 months of 2012'' for ''and 2011'' wherever appearing.

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 112–78, § 309(2), substituted '', 2011, or the first 2 months of 2012'' for ''or 2011''.

Subsec. (d)(13). Pub. L. 112–78, § 301, added par. (13).

Subsec. (e)(1)(E). Pub. L. 112–78, § 303, substituted ''before March 1, 2012'' for ''before January 1, 2012''.

2010—Subsec. (a)(8). Pub. L. 111–148, § 3002(b), added par. (8).

Subsec. (b)(1). Pub. L. 111–148, § 3007(1), inserted ''subject to subsection (p),'' after ''1998,'' in introductory provisions.

Subsec. (b)(4)(B). Pub. L. 111–152, § 1107(1)(A), substituted ''subparagraph (A)'' for ''this paragraph''.

Pub. L. 111–148, § 3135(a)(1)(A), substituted ''this paragraph'' for ''subparagraph (A)''.

Pub. L. 111–148, § 3111(a)(1)(A)(i), inserted '', and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))'' before the period.

Subsec. (b)(4)(C). Pub. L. 111–152, §1107(1)(B), amended subpar. (C) generally. Prior to amendment, text read as follows: ''Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1395m(e)(1)(B) of this title) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

''(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

''(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

''(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''

Pub. L. 111–148, §3135(a)(1)(B), added subpar. (C).

Subsec. (b)(4)(D). Pub. L. 111–148, §3135(b)(1), added subpar. (D).

Subsec. (b)(6). Pub. L. 111–148, §3111(a)(1)(A)(ii), added par. (6).

Subsec. (b)(7). Pub. L. 111–286, §3(a), added par. (7).

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 111–148, §3111(a)(1)(B), added subcl. (IV).

Subsec. (c)(2)(B)(v)(III) to (V). Pub. L. 111–152, §1107(2), added subcl. (III) and struck out former subcls. (III) to (V), which read as follows:

''(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

''(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

''(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.''

Pub. L. 111–148, §3135(a)(2), added subcls. (III) to (V).

Subsec. (c)(2)(B)(v)(VI). Pub. L. 111–148, §3135(b)(2), added subcl. (VI).

Subsec. (c)(2)(B)(v)(VII). Pub. L. 111–286, §3(b), added subcl. (VII).

Subsec. (c)(2)(B)(vii). Pub. L. 111–148, §5501(c), which directed the addition of cl. (vii), was repealed by Pub. L. 111–148, §10501(h). As enacted, text read as follows: ''Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1395*l* of this title for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1395*l*(m) of this title by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 254e(a)(1)(A) of this title) as health professional shortage areas.''

Subsec. (c)(2)(K), (L). Pub. L. 111–148, §3134(a), added subpars. (K) and (L).

Subsec. (d)(10). Pub. L. 111–192, §101(a)(1), substituted ''January through May'' for ''portion'' in heading.

Pub. L. 111–148, §3101, which directed the addition of par. (10) relating to update for 2010, was repealed by Pub. L. 111–148, §10310. As enacted, text read as follows:

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''

Subsec. (d)(10)(A). Pub. L. 111–157, §4(1), substituted ''May 31, 2010'' for ''March 31, 2010''.

Pub. L. 111–144, §5(1), substituted ''March 31, 2010'' for ''February 28, 2010''.

Subsec. (d)(10)(B). Pub. L. 111–157, §4(2), substituted ''June 1, 2010'' for ''April 1, 2010''.

Pub. L. 111–144, §5(2), substituted ''April 1, 2010'' for ''March 1, 2010''.

Subsec. (d)(11). Pub. L. 111–286, §2(1), substituted ''December'' for ''November'' in heading.

Pub. L. 111–192, §101(a)(2), added par. (11).

Subsec. (d)(11)(A). Pub. L. 111–286, §2(2), substituted ''December 31'' for ''November 30''.

Subsec. (d)(11)(B). Pub. L. 111–286, §2(3), substituted ''2011'' for ''remaining portion of 2010'' in heading and struck out ''the period beginning on December 1, 2010, and ending on December 31, 2010, and for'' before ''2011 and subsequent years'' in text.

Subsec. (d)(12). Pub. L. 111–309, §101, added par. (12).

Subsec. (e)(1)(A). Pub. L. 111–148, §10324(c)(1), substituted ''(H), and (I)'' for ''and (H)'' in introductory provisions.

Pub. L. 111–148, §3102(b)(1), substituted ''(G), and (H)'' for ''and (G)'' in introductory provisions.

Subsec. (e)(1)(E). Pub. L. 111–309, §103, substituted ''before January 1, 2012'' for ''before January 1, 2011''.

Pub. L. 111–148, §3102(a), substituted ''before January 1, 2011'' for ''before January 1, 2010''.

Subsec. (e)(1)(H). Pub. L. 111–148, §3102(b)(2), added subpar. (H).

Subsec. (e)(1)(H)(i). Pub. L. 111–152, §1108, substituted ''½'' for ''¾''.

Subsec. (e)(1)(I). Pub. L. 111–148, §10324(c)(2), added subpar. (I).

Subsec. (j)(3). Pub. L. 111–148, §4103(c)(2), inserted ''(2)(FF) (including administration of the health risk assessment),'' after ''(2)(EE),''.

Subsec. (k)(4). Pub. L. 111–148, §3002(c)(1), inserted ''or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry'' after ''Database)''.

Subsec. (m)(1)(A). Pub. L. 111–148, §3002(a)(1)(A), substituted ''2014'' for ''2010'' in introductory provisions.

Subsec. (m)(1)(B)(iii), (iv). Pub. L. 111–148, §3002(a)(1)(B), added cls. (iii) and (iv).

Subsec. (m)(3)(A). Pub. L. 111–148, §3002(a)(2)(A), inserted ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period'' in introductory provisions.

Subsec. (m)(3)(C)(i). Pub. L. 111–148, §3002(a)(2)(B), inserted '', or, for purposes of subsection (a)(8), for a quality reporting period for the year'' after ''(a)(5), for a reporting period for a year''.

Subsec. (m)(5)(E). Pub. L. 111–148, §3002(f)(1), substituted ''Except as provided in subparagraph (I), there shall'' for ''There shall'' in introductory provisions.

Subsec. (m)(5)(E)(iv). Pub. L. 111–148, §3002(a)(3), substituted ''paragraphs (5)(A) and (8)(A) of subsection (a)'' for ''subsection (a)(5)(A)''.

Subsec. (m)(5)(H), (I). Pub. L. 111–148, §3002(e), (f)(2), added subpars. (H) and (I).

Subsec. (m)(6)(C)(i)(II). Pub. L. 111–148, §3002(a)(4)(A), substituted ''and subsequent years'' for '', 2009, 2010, and 2011''.

Subsec. (m)(6)(C)(iii). Pub. L. 111–148, §3002(a)(4)(B), inserted ''(a)(8)'' after ''(a)(5)'' and substituted ''under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively'' for ''under subparagraph (D)(iii) of such subsection''.

Subsec. (m)(7). Pub. L. 111–148, §10327(a), added par. (7) relating to additional incentive payment.

Pub. L. 111–148, §3002(d), added par. (7) relating to integration of physician quality reporting and EHR reporting.

Subsec. (n)(1)(A). Pub. L. 111–148, §3003(a)(1)(A), designated existing provisions as cl. (i), inserted heading, substituted ''the 'Program').'' for ''the 'Program') under which the Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.'', and added cls. (ii) and (iii).

Subsec. (n)(1)(B). Pub. L. 111–148, §3003(a)(1)(B), substituted ''subparagraph (A)(ii)'' for ''subparagraph (A)'' in introductory provisions.

Subsec. (n)(4). Pub. L. 111–148, §3003(a)(2)(B), inserted ''initial'' after ''focus the'' in introductory provisions.

Pub. L. 111–148, §3003(a)(2)(A), inserted ''initial'' after ''focus'' in heading.

Subsec. (n)(6). Pub. L. 111–148, §3003(a)(3), inserted at end ''For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.''

Subsec. (n)(9), (10). Pub. L. 111–148, §3003(a)(4), added pars. (9) and (10).

Subsec. (*o*)(1)(C)(ii). Pub. L. 111–157, §5(a)(1), substituted ''inpatient or emergency room setting'' for ''setting (whether inpatient or outpatient)''.

Subsec. (p). Pub. L. 111–148, §3007(2), added subsec. (p).

2009—Subsec. (a)(5)(A)(i). Pub. L. 111–5, §4101(f)(1)(A), substituted '', 2013 or 2014'' for ''or any subsequent year''.

Subsec. (a)(5)(A)(ii)(III). Pub. L. 111–5, §4101(f)(1)(B), struck out ''and each subsequent year'' after ''2014''.

Subsec. (a)(7). Pub. L. 111–5, §4101(b), added par. (7).

Subsec. (d)(10). Pub. L. 111–118 added par. (10).

Subsec. (m)(2)(A). Pub. L. 111–5, §4101(f)(2)(A), substituted ''Subject to subparagraph (D), for 2009'' for ''For 2009''.

Subsec. (m)(2)(D). Pub. L. 111–5, §4101(f)(2)(B), added subpar. (D).

Subsec. (*o*). Pub. L. 111–5, §4101(a), added subsec. (*o*).

2008—Subsec. (a)(4)(A). Pub. L. 110–275, §139(a)(1), inserted ''except as provided in paragraph (5),'' after ''anesthesia cases,''.

Subsec. (a)(5). Pub. L. 110–275, §132(b), added par. (5).

Subsec. (a)(6). Pub. L. 110–275, §139(a)(2), added par. (6).

Subsec. (b)(5). Pub. L. 110–275, §144(a)(2)(B), added par. (5).

Subsec. (c)(2)(B)(vi). Pub. L. 110–275, §133(b), added cl. (vi).

Subsec. (d)(8). Pub. L. 110–275, §131(a)(1)(A)(i), struck out ''a portion of'' before ''2008'' in heading.

Subsec. (d)(8)(A). Pub. L. 110–275, §131(a)(1)(A)(ii), struck out ''for the period beginning on January 1, 2008, and ending on June 30, 2008,'' after ''for 2008,''.

Subsec. (d)(8)(B). Pub. L. 110–275, §131(a)(1)(A)(iii), struck out ''the remaining portion of 2008 and'' before ''2009'' in heading and ''for the period beginning on July 1, 2008, and ending on December 31, 2008, and'' before ''for 2009'' in text.

Subsec. (d)(9). Pub. L. 110–275, §131(a)(1)(B), added par. (9).

Subsec. (e)(1)(A). Pub. L. 110–275, §134(c), amended Pub. L. 108–173, §602(1). See 2003 Amendment note below.

Subsec. (e)(1)(E). Pub. L. 110–275, §134(a), substituted ''before January 1, 2010'' for ''before July 1, 2008''.

Subsec. (e)(1)(G). Pub. L. 110–275, §134(b), inserted at end ''For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5''.

Subsec. (j)(3). Pub. L. 110–275, §152(b)(1)(C), inserted ''(2)(EE),'' after ''(2)(DD),''.

Pub. L. 110–275, §144(a)(2)(A), inserted ''(2)(DD),'' after ''(2)(AA),''.

Subsec. (k)(2)(C), (D). Pub. L. 110–275, §131(b)(1), added subpars. (C) and (D).

Subsec. (k)(3)(B)(iv). Pub. L. 110–275, §131(b)(4)(A), added cl. (iv).

Subsec. (*l*)(2)(A)(i)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (III) which read as follows: ''For expenditures during 2013, an amount equal to $4,670,000,000.''

Pub. L. 110–252, §7002(c)(1)(A), substituted ''$4,670,000,000'' for ''$4,960,000,000''.

Subsec. (*l*)(2)(A)(i)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (IV) which read as follows: ''For expenditures during 2014, an amount equal to $290,000,000.''

Pub. L. 110–252, §7002(c)(1)(B), added subcl. (IV).

Subsec. (*l*)(2)(A)(ii)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (III). Text read as follows: ''The amount available for expenditures during 2013 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''

Subsec. (*l*)(2)(A)(ii)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (IV). Text read as follows: ''The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''

Pub. L. 110–252, §7002(c)(2), added subcl. (IV).

Subsec. (*l*)(2)(B). Pub. L. 110–275, §131(a)(3)(C)(ii), inserted ''and'' at end of cl. (i), substituted period for semicolon at end of cl. (ii), and struck out cls. (iii) and (iv) which read as follows:

''(iii) 2013 for payment with respect to physicians' services furnished during 2013; and

''(iv) 2014 for payment with respect to physicians' services furnished during 2014.''

Subsec. (*l*)(2)(B)(iv). Pub. L. 110–252, §7002(c)(3), added cl. (iv).

Subsec. (m). Pub. L. 110–275, §131(b)(2), (3)(A), transferred subsec. (c) of section 101 of title I of div. B of Pub. L. 109–432 to subsec. (m) of this section and amended heading generally. Prior to amendment, heading read ''Transitional Bonus Incentive Payments for Quality Reporting in 2007 and 2008''. See Codification note above.

Subsec. (m)(1). Pub. L. 110–275, §131(b)(3)(B), added par. (1) and struck out former par. (1) which provided for an additional payment for certain covered professional services furnished by an eligible professional.

Subsec. (m)(2). Pub. L. 110–275, §132(a)(1), added par. (2). Former par. (2) redesignated (3).

Subsec. (m)(3). Pub. L. 110–275, §132(a)(2)(A), inserted ''and successful electronic prescriber'' after ''reporting'' in heading.

Pub. L. 110–275, §131(b)(3)(D)(i), (ii), designated existing provisions as subpar. (A) and inserted heading, redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), and realigned margins.

Pub. L. 110–275, §131(b)(3)(C), redesignated par. (2) as (3) and struck out former par. (3) which provided for payment limitation.

Subsec. (m)(3)(A). Pub. L. 110–275, §131(b)(3)(D)(iii), inserted concluding provisions.

Subsec. (m)(3)(B). Pub. L. 110–275, §132(a)(2)(B), added subpar. (B). Former subpar. (B) redesignated cl. (i) of subpar. (A).

Subsec. (m)(3)(C), (D). Pub. L. 110–275, §131(b)(3)(D)(iv), added subpars. (C) and (D).

Subsec. (m)(5)(A). Pub. L. 110–275, §131(b)(5)(A)(i), substituted ''subsection (k)'' for ''section 1848(k) of the So-

cial Security Act, as added by subsection (b),'' and ''such subsection'' for ''such section''.

Subsec. (m)(5)(B). Pub. L. 110–275, §131(b)(5)(A)(ii), struck out ''of the Social Security Act (42 U.S.C. 1395*l*)'' before ''and any payment''.

Subsec. (m)(5)(C). Pub. L. 110–275, §131(b)(3)(E)(i), inserted ''for 2007, 2008, and 2009,'' after ''provision of law,''.

Subsec. (m)(5)(D)(i). Pub. L. 110–275, §131(b)(3)(E)(ii)(I), which directed amendment of cl. (i) by inserting ''for 2007 and 2008'' after ''under this subsection'' and then substituting ''this subsection'' for ''paragraph (2)'', was executed by substituting ''under this subsection for 2007 and 2008'' for ''under paragraph (2)'' to reflect the probable intent of Congress.

Subsec. (m)(5)(D)(ii). Pub. L. 110–275, §131(b)(3)(E)(ii)(II), substituted ''may establish procedures to'' for ''shall''.

Subsec. (m)(5)(D)(iii). Pub. L. 110–275, §131(b)(3)(E)(ii)(III), inserted ''(or, in the case of a group practice under paragraph (3)(C), the group practice)'' after ''an eligible professional'', substituted ''incentive payment under this subsection'' for ''bonus incentive payment'', and inserted at end ''If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).''

Subsec. (m)(5)(E). Pub. L. 110–275, §131(b)(5)(A)(iii), substituted ''1395ff of this title, section 1395*oo* of this title, or otherwise'' for ''1869 or 1878 of the Social Security Act or otherwise''.

Pub. L. 110–275, §131(b)(3)(E)(iii)(I)–(III), struck out cl. (i) designation and heading before ''There shall be'', redesignated subcls. (I) to (IV) as cls. (i) to (iv), respectively, and struck out former cl. (ii). Prior to amendment, text of cl. (ii) read as follows: ''A determination under this subsection shall not be treated as a determination for purposes of section 1869 of the Social Security Act.''

Subsec. (m)(5)(E)(ii). Pub. L. 110–275, §131(b)(3)(E)(iii)(IV), substituted ''this subsection'' for ''paragraph (2)''.

Subsec. (m)(5)(E)(iii). Pub. L. 110–275, §132(a)(3), added cl. (iii) and struck out former cl. (iii) which read as follows: ''the determination of the payment limitation under paragraph (3); and''.

Subsec. (m)(5)(E)(iv). Pub. L. 110–275, §131(b)(3)(E)(iii)(V), substituted ''any'' for ''the bonus'' and inserted ''and the payment adjustment under subsection (a)(5)(A)'' before period at end.

Subsec. (m)(5)(F). Pub. L. 110–275, §131(b)(3)(E)(iv), (5)(A)(iv), substituted ''subsequent years,'' for ''2009, paragraph (3) shall not apply, and'', ''this subsection'' for ''paragraph (2)'', ''subsection (k)(2)(B)'' for ''paragraph (2)(B) of section 1848(k)'' of the Social Security Act (42 U.S.C. 1395w–4(k))'', and ''subsection (k)(4)'' for ''paragraph (4) of such section''.

Subsec. (m)(5)(G). Pub. L. 110–275, §131(b)(3)(E)(v), added subpar. (G).

Subsec. (m)(6)(A). Pub. L. 110–275, §131(b)(5)(B)(i), substituted ''subsection (k)(3)'' for ''section 1848(k)(3) of the Social Security Act, as added by subsection (b)''.

Subsec. (m)(6)(B). Pub. L. 110–275, §131(b)(5)(B)(ii), substituted ''subsection (k)'' for ''section 1848(k) of the Social Security Act, as added by subsection (b)''.

Subsec. (m)(6)(C). Pub. L. 110–275, §131(b)(3)(F), added subpar. (C) and struck out former subpar. (C). Prior to amendment, text read as follows: ''The term 'reporting period' means—

''(i) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

''(ii) for 2008, all of 2008.''

Subsec. (m)(6)(D). Pub. L. 110–275, §131(b)(5)(C), struck out subpar. (D). Text read as follows: ''The term 'Secretary' means the Secretary of Health and Human Services.''

Subsec. (n). Pub. L. 110–275, §131(c)(1), added subsec. (n).

2007—Subsec. (d)(4)(B). Pub. L. 110–173, §101(a)(1)(A), substituted ''and the succeeding paragraphs of this subsection'' for ''and paragraphs (5) and (6)'' in introductory provisions.

Subsec. (d)(8). Pub. L. 110–173, §101(a)(1)(B), added par. (8).

Subsec. (e)(1)(E). Pub. L. 110–173, §103, substituted ''before July 1, 2008'' for ''before January 1, 2008''.

Subsec. (k)(2)(B). Pub. L. 110–173, §101(b)(1), in heading and cl. (i), inserted ''and 2009'' after ''2008'', and, in cls. (ii) and (iii), substituted ''of each of 2007 and 2008'' for '', 2007'' and inserted ''or 2009, as applicable'' after ''2008''.

Subsec. (*l*)(2)(A). Pub. L. 110–173, §101(a)(2)(A)(i), added subpar. (A) and struck out former subpar. (A), which read as follows: ''There shall be available to the Fund for expenditures an amount equal to $1,200,000,000, as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008). In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000, as reduced by section 225(c)(1)(B) of such Act, and for expenditures during or after 2013 an amount equal to $60,000,000.''

Pub. L. 110–161, §524, which directed amendment of subpar. (A) by reducing the dollar amount in the first sentence by $150,000,000, was executed by substituting ''$1,200,000,000'' for ''$1,350,000,000'' in first sentence.

Pub. L. 110–161, §225(c)(2), inserted, in first sentence, '', as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008)'' after ''$1,350,000,000'' and, in second sentence, '', as reduced by section 225(c)(1)(B) of such Act,'' after ''$325,000,000''.

Pub. L. 110–90, §6(1), inserted at end: ''In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000 and for expenditures during or after 2013 an amount equal to $60,000,000.''

Subsec. (*l*)(2)(B). Pub. L. 110–173, §101(a)(2)(A)(ii), substituted ''entire amount available for expenditures, after application of subparagraph (A)(ii), during—'' and cls. (i) to (iii) for ''entire amount specified in the first sentence of subparagraph (A) for payment with respect to physicians' services furnished during 2008 and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013.''

Pub. L. 110–90, §6(2), in heading, struck out ''furnished during 2008'' after ''services'' and, in text, substituted ''specified in the first sentence of subparagraph (A)'' for ''specified in subparagraph (A)'' and inserted ''and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013'' after ''furnished during 2008''.

2006—Subsec. (b)(4). Pub. L. 109–171, §5102(b)(1), added par. (4).

Subsec. (c)(2)(B)(ii)(II). Pub. L. 109–171, §5102(a)(1), substituted ''clauses (iv) and (v)'' for ''clause (iv)''.

Subsec. (c)(2)(B)(iv). Pub. L. 109–171, §5102(a)(2), inserted ''of certain additional expenditures'' after ''Exemption'' in heading.

Subsec. (c)(2)(B)(v). Pub. L. 109–171, §5102(a)(3), added cl. (v).

Subsec. (c)(2)(B)(v)(II). Pub. L. 109–171, §5102(b)(2), added subcl. (II).

Subsec. (d)(4)(B). Pub. L. 109–171, §5104(a)(1), substituted ''paragraphs (5) and (6)'' for ''paragraph (5)'' in introductory provisions.

Subsec. (d)(6). Pub. L. 109–171, §5104(a)(2), added par. (6).

Subsec. (d)(7). Pub. L. 109–432, §101(a), added par. (7).

Subsec. (e)(1)(E). Pub. L. 109–432, §102, substituted ''2008'' for ''2007''.

Subsec. (j)(3). Pub. L. 109–171, §5112(c), inserted ''(2)(AA),'' after ''(2)(W),''.

Subsec. (k). Pub. L. 109–432, §101(b), added subsec. (k).

Subsec. (*l*). Pub. L. 109–432, §101(d), added subsec. (*l*).

2003—Subsec. (c)(2)(B)(ii)(II). Pub. L. 108–173, §303(a)(1)(A)(i), substituted ''Subject to clause (iv), the adjustments'' for ''The adjustments''.

Subsec. (c)(2)(B)(iv). Pub. L. 108–173, §303(a)(1)(A)(ii), added cl. (iv).

Subsec. (c)(2)(H) to (J). Pub. L. 108–173, §303(a)(1)(B), added subpars. (H) to (J).

Subsec. (d)(4)(B). Pub. L. 108–173, §601(a)(2), inserted ''and paragraph (5)'' after ''subparagraph (D)'' in introductory provisions.

Subsec. (d)(5). Pub. L. 108–173, §601(a)(1), added par. (5).

Subsec. (e)(1)(A). Pub. L. 108–173, §602(1), as amended by Pub. L. 110–275, §134(c), substituted ''subparagraphs (B), (C), (E), and (G)'' for ''subparagraphs (B), (C), and (E)''.

Pub. L. 108–173, §412(1), substituted ''subparagraphs (B), (C), and (E)'' for ''subparagraphs (B) and (C)''.

Subsec. (e)(1)(E). Pub. L. 108–173, §412(2), added subpar. (E).

Subsec. (e)(1)(G). Pub. L. 108–173, §602(2), added subpar. (G).

Subsec. (f)(2)(C). Pub. L. 108–173, §601(b)(1), substituted ''annual average'' for ''projected'' and ''during the 10-year period ending with the applicable period involved'' for ''from the previous applicable period to the applicable period involved''.

Subsec. (i)(1)(B). Pub. L. 108–173, §303(g)(2), substituted ''subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)'' for ''subsection (c)(2)(F)''.

Subsec. (i)(1)(C). Pub. L. 108–7 amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''the determination of conversion factors under subsection (d) of this section,''.

Subsec. (i)(3)(A). Pub. L. 108–173, §736(b)(10), substituted ''comparable services'' for ''a comparable services''.

Subsec. (j)(3). Pub. L. 108–173, §611(c), inserted ''(2)(W),'' after ''(2)(S),''.

2000—Subsec. (j)(3). Pub. L. 106–554 inserted ''(13),'' after ''(4),''.

1999—Subsec. (d)(1)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(i)], inserted ''(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved'' before period at end.

Subsec. (d)(1)(E). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(2)(A)], amended heading and text of subpar. (E) generally. Prior to amendment, text read as follows: ''The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

''(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update determined under paragraph (3) for 1992; and

''(ii) each succeeding year, the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.''

Subsec. (d)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(i)], inserted ''for 1999 and 2000'' after ''Update'' in heading.

Subsec. (d)(3)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(ii)], substituted ''1999 and 2000'' for ''a year beginning with 1999'' in introductory provisions.

Subsec. (d)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(iii)], inserted ''and paragraph (4)'' after ''For purposes of this paragraph'' in introductory provisions.

Subsec. (d)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(B)], added par. (4).

Subsec. (f)(1). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(1)], amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997.''

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(A)], substituted ''fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000'' for ''fiscal year 1998)'' in introductory provisions.

Subsec. (f)(2)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted ''applicable period'' for ''fiscal year''.

Subsec. (f)(2)(B), (C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted ''applicable period'' for ''fiscal year'' in two places.

Subsec. (f)(2)(D). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(ii), (b)(2)(B)], substituted ''applicable period'' for ''fiscal year'' in two places and ''subsection (d)(3)(B) or (d)(4)(B), as the case may be'' for ''subsection (d)(3)(B)''.

Subsec. (f)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(5)], added par. (3). Former par. (3) redesignated (4).

Subsec. (f)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(3)], added subpar. (C).

Subsec. (f)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(4)], redesignated par. (3) as (4).

Subsec. (j)(3). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(5)], substituted ''section 1395x(*oo*)(2) of this title)'' for ''section 1395x(*oo*)(2) of this title,'', ''(B),'' for ''(B),'', and '', and (15)'' for ''and (15)''.

1997—Subsec. (b)(1). Pub. L. 105–33, §4644(d), substituted ''Before November 1 of the preceding year, for each year beginning with 1998'' for ''Before January 1 of each year beginning with 1992'' in introductory provisions.

Subsec. (c)(2)(B)(iii). Pub. L. 105–33, §4022(b)(2)(C), substituted ''Medicare Payment Advisory Commission'' for ''Physician Payment Review Commission''.

Subsec. (c)(2)(C)(ii). Pub. L. 105–33, §4505(b)(1)(A), which directed an amendment striking the comma at the end of cl. (ii) and inserting a period and the following: ''For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.'', was executed by making the insertion at end of cl. (ii) to reflect the probable intent of Congress, because cl. (ii) ended with a period rather than a comma.

Pub. L. 105–33, §4505(a)(1), substituted ''1999'' for ''1998'' in two places.

Subsec. (c)(2)(C)(iii). Pub. L. 105–33, §4505(f)(1)(A), inserted ''for the service for years before 2000'' before ''equal'' in introductory provisions, substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (c)(2)(G). Pub. L. 105–33, §4505(e), added subpar. (G).

Subsec. (c)(3)(C)(ii). Pub. L. 105–33, §4505(b)(2), substituted ''2002'' for ''1999'' in introductory provisions.

Pub. L. 105–33, §4505(a)(2), substituted ''1999'' for ''1998'' in introductory provisions.

Subsec. (c)(3)(C)(iii). Pub. L. 105–33, §4505(f)(1)(B), substituted ''For years before 1999, the malpractice'' for ''The malpractice'' in introductory provisions.

Subsec. (d)(1)(A). Pub. L. 105–33, §4501(b)(1), (2), struck out ''(or factors)'' after ''conversion factor'' in two places and struck out ''or updates'' after ''update''.

Subsec. (d)(1)(C). Pub. L. 105–33, §4504(a)(1), substituted ''Except as provided in subparagraph (D), the single conversion factor'' for ''The single conversion factor''.

Pub. L. 105–33, § 4501(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (d)(1)(D). Pub. L. 105–33, § 4504(a)(3), added subpar. (D). Former subpar. (D) redesignated (E).

Pub. L. 105–33, § 4501(b)(1), (3), struck out ''(or updates)'' after ''update'' in two places and struck out ''(or factors)'' after ''conversion factor'' in cl. (ii).

Pub. L. 105–33, § 4501(a)(1), redesignated subpar. (C) as (D).

Subsec. (d)(1)(E). Pub. L. 105–33, § 4504(a)(2), redesignated subpar. (D) as (E).

Subsec. (d)(2). Pub. L. 105–33, § 4502(b), struck out heading and text of par. (2) which related to recommendation of update.

Subsec. (d)(2)(F). Pub. L. 105–33, § 4022(b)(1)(B)(i), struck out heading and text of subpar. (F). Text read as follows: ''The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.''

Subsec. (d)(3). Pub. L. 105–33, § 4502(a)(1), amended heading and text generally. Prior to amendment, text related to updates of conversion factor based on index and made provision for adjustments in update.

Subsec. (f). Pub. L. 105–33, § 4503(b), amended subsec. heading and heading and text of par. (1) generally. Prior to amendment, par. (1) related to process for establishing medicare volume performance standard rates of increase.

Subsec. (f)(1)(B). Pub. L. 105–33, § 4022(b)(2)(B)(ii), struck out heading and text of subpar. (B). Text read as follows: ''The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.''

Subsec. (f)(2). Pub. L. 105–33, § 4503(a), added par. (2) and struck out heading and text of former par. (2) which related to specification of performance standard rates of increase for physician services for fiscal years beginning in 1991.

Subsec. (f)(3). Pub. L. 105–33, § 4503(a), added par. (3) and struck out heading and text of former par. (3). Text read as follows: ''The Secretary shall establish procedures for providing, on a quarterly basis to the the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.''

Pub. L. 105–33, § 4022(b)(2)(B)(iii), struck out ''Physician Payment Review Commission,'' before ''the Congressional Budget Office''.

Subsec. (f)(4), (5). Pub. L. 105–33, § 4503(a), struck out heading and text of par. (4) which related to separate group-specific performance standard rates of increase and par. (5) which defined ''physicians' services'' and ''HMO enrollee''.

Subsec. (g)(3)(A). Pub. L. 105–33, § 4714(b)(2), inserted before period at end ''and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section''.

Subsec. (g)(6)(C), (7)(C). Pub. L. 105–33, § 4022(b)(2)(C), substituted ''Medicare Payment Advisory Commission'' for ''Physician Payment Review Commission''.

Subsec. (j)(1). Pub. L. 105–33, § 4501(b)(4), substituted ''For services furnished before January 1, 1998, the term'' for ''The term''.

Subsec. (j)(3). Pub. L. 105–33, § 4106(b), substituted ''(4), (14)'' for ''(4) and (14)'' and inserted ''and (15)'' after ''1395x(nn)(2) of this title)''.

Pub. L. 105–33, § 4105(a)(2), inserted ''(2)(S),'' before ''(3)''.

Pub. L. 105–33, § 4103(d), inserted ''(2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(*oo*)(2) of this title,'' after ''(2)(G)''.

Pub. L. 105–33, §§ 4102(d), 4104(d), inserted ''(2)(R) (with respect to services described in subparagraphs (B) , (C), and (D) of section 1395x(pp)(1) of this title),'' before ''(3)'' and substituted ''(4) and (14) (with respect to services described in section 1395x(nn)(2) of this title)'' for ''and (4)''.

1994—Subsec. (a)(2)(D)(iii). Pub. L. 103–432, § 126(b)(6), struck out ''that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' after ''nuclear medicine services'' and substituted ''provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' for ''provided under such section''.

Subsec. (c)(2)(C)(ii). Pub. L. 103–432, § 121(b)(1), inserted ''for the service for years before 1998'' before ''equal to'' in introductory provisions, substituted comma for period at end of subcl. (II), and inserted ''and for years beginning with 1998 based on the relative practice expense resources involved in furnishing the service.'' as closing provisions.

Subsec. (c)(3)(C)(ii). Pub. L. 103–432, § 121(b)(2), substituted ''For years before 1998, the practice'' for ''The practice''.

Subsec. (c)(4). Pub. L. 103–432, § 126(g)(6), made technical amendment to directory language of Pub. L. 101–508, § 4118(f)(1)(D). See 1990 Amendment note below.

Subsec. (e)(1)(C). Pub. L. 103–432, § 126(g)(5), inserted ''date of the'' before ''last previous adjustment''.

Pub. L. 103–432, § 122(a), substituted ''shall, in consultation with appropriate representatives of physicians, review'' for ''shall review''.

Subsec. (e)(1)(D). Pub. L. 103–432, § 122(b), added subpar. (D).

Subsec. (f)(2)(A)(i). Pub. L. 103–432, § 126(g)(7), made technical amendment to directory language of Pub. L. 101–508, § 4118(f)(1)(N)(ii). See 1990 Amendment note below.

Subsec. (f)(2)(C). Pub. L. 103–432, § 126(g)(2)(B), inserted heading.

Subsec. (g)(1). Pub. L. 103–432, § 123(a)(1), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''If a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) knowingly and willfully bills on a repeated basis for physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3) of this section, furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician, supplier, or other person in accordance with section 1395u(j)(2) of this title. In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.''

Subsec. (g)(3)(B). Pub. L. 103–432, § 123(a)(2), inserted after first sentence ''No person is liable for payment of any amounts billed for such a service in violation of the previous sentence.'' and in last sentence substituted ''first sentence'' for ''previous sentence''.

Subsec. (g)(6)(B). Pub. L. 103–432, § 123(d), inserted ''information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information'' after ''report to the Congress''.

Subsec. (i)(3). Pub. L. 103–432, § 126(g)(10)(A), struck out space before the period at end.

1993—Subsec. (a)(2)(B)(ii)(I). Pub. L. 103–66, § 13515(c)(1), inserted ''and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993'' after ''subsection (c)(2)(F)(ii)''.

Pub. L. 103–66, § 13514(c)(1), inserted ''and as adjusted under subsection (c)(2)(F)(ii)'' after ''for 1994''.

Subsec. (a)(3). Pub. L. 103–66, § 13517(a)(1), in heading inserted ''and suppliers'' after ''physicians'' and in text inserted ''or a nonparticipating supplier or other person'' after ''nonparticipating physician'' and inserted at end ''In the case of physicians' services (including

services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.''

Subsec. (a)(4). Pub. L. 103–66, § 13516(a)(1), added par. (4).

Pub. L. 103–66, § 13515(a)(1), struck out heading and text of par. (4). Text read as follows: ''In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1395ww(d)(2) of this title) that is designated under section 249(a)(1)(A) of this title as a health manpower shortage area.''

Subsec. (b)(3). Pub. L. 103–66, § 13514(a), amended heading and text of par. (3) generally. Prior to amendment, text read as follows: ''If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1395u(j)(2) of this title.''

Subsec. (c)(2)(A)(i). Pub. L. 103–66, § 13515(c)(2), inserted before period at end ''and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993''.

Pub. L. 103–66, § 13514(c)(2), inserted at end ''Such relative values are subject to adjustment under subparagraph (F)(i).''

Subsec. (c)(2)(E). Pub. L. 103–66, § 13513, added subpar. (E).

Subsec. (c)(2)(F). Pub. L. 103–66, § 13514(b), added subpar. (F).

Subsec. (d)(3)(A)(i). Pub. L. 103–66, § 13511(a)(1)(A), substituted ''clauses (iii) through (v)'' for ''clause (iii)''.

Subsec. (d)(3)(A)(iv) to (vi). Pub. L. 103–66, § 13511(a)(1)(B), added cls. (iv) to (vi).

Subsec. (d)(3)(B)(ii). Pub. L. 103–66, § 13512(b), substituted ''1994'' for ''1994 or 1995'' in subcl. (II) and ''5'' for ''3'' in subcl. (III).

Subsec. (f)(2)(B). Pub. L. 103–66, § 13512(a), added cls. (iii) to (v) and struck out former cl. (iii) which read as follows: ''for each succeeding year is 2 percentage points.''

Subsec. (g)(1). Pub. L. 103–66, § 13517(a)(2)(C), (D), inserted '', supplier, or other person'' after ''such physician'' and inserted at end ''In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.''

Pub. L. 103–66, § 13517(a)(2)(B), which directed insertion of ''including services which the Secretary excludes pursuant to subsection (j)(3) of this section,'' after ''physician's services ('', was executed by making the insertion after ''physicians' services ('' to reflect the probable intent of Congress.

Pub. L. 103–66, § 13517(a)(2)(A), inserted ''or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title)'' after ''nonparticipating physician''.

Subsec. (g)(2)(C). Pub. L. 103–66, § 13517(a)(3), inserted ''or for nonparticipating suppliers or other persons'' after ''nonparticipating physicians''.

Subsec. (g)(2)(D). Pub. L. 103–66, § 13517(a)(4), inserted ''(or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis)'' after ''subsection (a)''.

Subsec. (h). Pub. L. 103–66, § 13517(a)(5), inserted ''or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3))'' after ''each physician'', inserted '', supplier, or other person'' after ''by the physician'', and inserted '', suppliers, and other persons'' after ''notices to physicians''.

Subsec. (i)(1)(B). Pub. L. 103–66, § 13515(c)(3), inserted ''and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993'' after ''subsection (c)(2)(F)''.

Pub. L. 103–66, § 13514(c)(3), inserted at end ''including adjustments under subsection (c)(2)(F),''.

Subsec. (j)(1). Pub. L. 103–66, § 13511(a)(2), substituted ''Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title),'' for ''Secretary)''.

Subsec. (j)(3). Pub. L. 103–66, § 13518(a), inserted ''(2)(G),'' after ''(2)(D),''.

Pub. L. 103–66, § 13517(a)(6), inserted '', except for purposes of subsections (a)(3), (g), and (h)'' after ''tests and''.

1990—Subsec. (a)(1). Pub. L. 101–508, § 4104(b)(2), struck out ''or 1395m(f)'' after ''section 1395m(b)'' in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 101–508, § 4102(b), inserted ''and radiology'' after ''Special rule for anesthesia'' in heading and inserted at end ''With respect to radiology services, '109 percent' and '9 percent' shall be substituted for '115 percent' and '15 percent', respectively, in subparagraph (A)(ii).''

Subsec. (a)(2)(D)(ii). Pub. L. 101–508, § 4102(g)(2)(A), inserted '', but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' after ''section 1395m(b)(6) of this title)''.

Subsec. (a)(2)(D)(iii). Pub. L. 101–508, § 4102(g)(2)(B), added cl. (iii).

Subsec. (a)(4). Pub. L. 101–508, § 4106(b)(1), added par. (4).

Subsec. (b)(3). Pub. L. 101–508, § 4109(a), added par. (3).

Subsec. (c)(1)(B). Pub. L. 101–508, § 4118(f)(1)(A), struck out at end ''In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.''

Subsec. (c)(3). Pub. L. 101–508, § 4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4).

Subsec. (c)(3)(C)(ii)(II), (iii)(II). Pub. L. 101–508, § 4118(f)(1)(B), struck out ''by'' before ''the proportion''.

Subsec. (c)(4). Pub. L. 101–508, § 4118(f)(1)(D), as amended by Pub. L. 103–432, § 126(g)(6), substituted ''section'' for ''subsection''.

Pub. L. 101–508, § 4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4). Former par. (4) redesignated (5).

Pub. L. 101–508, § 4118(d), struck out ''only for services furnished on or after January 1, 1993'' after ''visits and consultations''.

Subsec. (c)(5), (6). Pub. L. 101–508, § 4118(f)(1)(C), redesignated pars. (4) and (5) as (5) and (6), respectively.

Subsec. (d)(1)(A). Pub. L. 101–508, § 4118(f)(1)(E), (F)(i)(III), amended subpar. (A) identically, substituting ''paragraph (3)'' for ''subparagraph (C)''.

Pub. L. 101–508, § 4118(f)(1)(F)(i)(I), (II), substituted ''conversion factor (or factors)'' for ''conversion factor'' in two places and ''update or updates'' for ''update''.

Subsec. (d)(1)(C)(i). Pub. L. 101–508, § 4118(f)(1)(F)(ii)(I), substituted ''conversion factor'' for ''conversion factor (or factors)''.

Subsec. (d)(1)(C)(ii). Pub. L. 101–508, § 4118(f)(1)(F)(ii)(II), inserted ''the conversion factor (or factors) which will apply to physicians' services for the following year and'' before ''the update (or updates)'' and substituted ''such year'' for ''the following year''.

Subsec. (d)(2)(A). Pub. L. 101–508, § 4118(f)(1)(G), (I), substituted ''physicians' services (as defined in subsection (f)(5)(A) of this section)'' for ''physicians' serv-

ices'' in first sentence and ''proportion of individuals who are enrolled under this part who are HMO enrollees'' for ''proportion of HMO enrollees'' in last sentence.

Subsec. (d)(2)(A)(ii). Pub. L. 101–508, §4118(f)(1)(H), substituted ''and for the services involved'' for ''(as defined in subsection (f)(5)(A) of this section)'' and ''such services'' for ''all such physicians' services''.

Subsec. (d)(2)(E)(i). Pub. L. 101–508, §4118(f)(1)(J), inserted ''the'' before ''most recent''.

Subsec. (d)(2)(E)(ii)(I). Pub. L. 101–508, §4118(f)(1)(K), substituted ''payments for physicians' services'' for ''physicians' services''.

Subsec. (d)(3)(A)(i). Pub. L. 101–508, §4105(a)(3)(A), inserted ''except as provided in clause (iii),'' after ''subparagraph (B),''.

Subsec. (d)(3)(A)(iii). Pub. L. 101–508, §4105(a)(3)(B), added cl. (iii).

Subsec. (d)(3)(B)(i). Pub. L. 101–508, §4118(f)(1)(L)(i)(II), which directed amendment of cl. (i) by substituting ''services in such category'' for ''physicians' services (as defined in subsection (f)(5)(A))'', was executed by making the substitution for ''physicians' services (as defined in section (f)(5)(A))'' to reflect the probable intent of Congress.

Pub. L. 101–508, §4118(f)(1)(L)(i)(I), substituted ''update for a category of physicians' services for a year'' for ''update for a year''.

Subsec. (d)(3)(B)(ii). Pub. L. 101–508, §4118(f)(1)(L)(ii), inserted ''more than'' after ''decrease of'' in introductory provisions and struck out ''more than'' before ''2 percentage points'' in subcl. (I).

Subsec. (e)(1)(A). Pub. L. 101–508, §4118(c)(1), substituted ''subparagraphs (B) and (C)'' for ''subparagraph (B)'' in introductory provisions.

Subsec. (e)(1)(C). Pub. L. 101–508, §4118(c)(2), added subpar. (C).

Subsec. (f)(1)(C). Pub. L. 101–508, §4105(c)(1), substituted ''1991'' for ''1990'' after ''beginning with''.

Subsec. (f)(1)(D)(i). Pub. L. 101–508, §4118(f)(1)(M), substituted ''portions of calendar years'' for ''calendar years''.

Subsec. (f)(2)(A). Pub. L. 101–508, §4118(b)(1), (f)(1)(N)(i), in introductory provisions, substituted ''the performance standard rate of increase, for all physicians' services and for each category of physicians' services,'' for ''each performance standard rate of increase'' and ''product'' for ''sum''.

Pub. L. 101–508, §4118(b)(6), substituted ''minus 1, multiplied by 100, and reduced'' for ''reduced'' in concluding provisions.

Subsec. (f)(2)(A)(i). Pub. L. 101–508, §4118(f)(1)(N)(ii), as amended by Pub. L. 103–432, §126(g)(7), substituted ''all physicians' services or for the category of physicians' services, respectively,'' for ''physicians' services (as defined in subsection (f)(5)(A) of this section)''.

Pub. L. 101–508, §4118(f)(1)(M), substituted ''portions of calendar years'' for ''calendar years''.

Pub. L. 101–508, §4118(b)(2), (3), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and ''percentage increase (divided by 100)'' for ''percentage increase''.

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, §4118(b)(2), (4), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and inserted ''(divided by 100)'' after ''decrease''.

Subsec. (f)(2)(A)(iii). Pub. L. 101–508, §4118(f)(1)(N)(iii), substituted ''all physicians' services or of the category of physicians' services, respectively,'' for ''physicians' services''.

Pub. L. 101–508, §4118(b)(2), (5), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and inserted ''(divided by 100)'' after ''percentage growth''.

Subsec. (f)(2)(A)(iv). Pub. L. 101–508, §4118(e), (f)(1)(N)(iv), substituted ''all physicians' services or of the category of physicians' services, respectively,'' for ''physicians' services (as defined in subsection (f)(5)(A) of this section)'' and inserted ''including changes in law and regulations affecting the percentage increase described in clause (i)'' after ''law or regulations''.

Pub. L. 101–508, §4118(b)(2), (4), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and ''decrease (divided by 100)'' for ''decrease''.

Subsec. (f)(2)(C). Pub. L. 101–508, §4105(c)(2), added subpar. (C).

Subsec. (f)(4)(A). Pub. L. 101–508, §4118(f)(1)(O), substituted ''subparagraph (B)'' for ''paragraph (B)''.

Subsec. (f)(4)(B). Pub. L. 101–508, §4118(f)(1)(P), substituted ''specifically approved by law'' for ''Congress specifically approves the plan''.

Subsec. (g)(2)(A). Pub. L. 101–508, §4118(f)(1)(Q), inserted ''other than radiologist services subject to section 1395m(b) of this title,'' after ''during 1991,'' in introductory provisions.

Pub. L. 101–508, §4116, inserted at end ''In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting '40 percent' for '25 percent'.''

Subsec. (g)(2)(B). Pub. L. 101–508, §4118(f)(1)(Q), inserted ''other than radiologist services subject to section 1395m(b) of this title,'' after ''during 1992,'' in introductory provisions.

Subsec. (i)(1)(A). Pub. L. 101–508, §4118(f)(1)(R), substituted ''adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)'' for ''historical payment basis (as defined in subsection (a)(2)(C)(i)''.

Subsec. (i)(2). Pub. L. 101–508, §4107(a)(1), added par. (2).

Subsec. (i)(3). Pub. L. 101–508, §4118(k), added par. (3).

Subsec. (j)(1). Pub. L. 101–508, §4118(f)(1)(S), which directed the amendment of par. (1) by substituting ''(as defined by the Secretary) and all other physicians' services'' for '', and such other'' and all that follows through the period was executed by making the substitution for '', and such other category or categories of physicians' services as the Secretary, from time to time, defines in regulation.'' to reflect the probable intent of Congress.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title I, §106(b)(2)(C), Apr. 16, 2015, 129 Stat. 140, provided that: ''The amendments made by this subsection [amending this section and section 1395ww of this title] shall apply to meaningful EHR users [which term has the meaning given under 42 U.S.C. 1395f(*l*)(3), 42 U.S.C. 1395w–4(*o*), 42 U.S.C. 1395w–23(*l*), (m), and 42 U.S.C. 1395ww(n)] as of the date that is one year after the date of the enactment of this Act [Apr. 16, 2015].''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–157, §5(b), Apr. 15, 2010, 124 Stat. 1117, provided that: ''The amendments made by subsection (a) [amending this section and section 1396b of this title] shall be effective as if included in the enactment of the HITECH Act [Pub. L. 111–5, div. A, title XIII, div. B, title IV] (included in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5)).''

Pub. L. 111–152, title I, §1108, Mar. 30, 2010, 124 Stat. 1050, provided that the amendment made by section 1108 is effective as if included in the enactment of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

Pub. L. 111–148, title III, §3002(c)(2), Mar. 23, 2010, 124 Stat. 365, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply for years after 2010.''

Amendment by section 4103(c)(2) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §144(a)(3), July 15, 2008, 122 Stat. 2547, provided that: ''The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2010.''

Pub. L. 110–275, title I, §152(b)(2), July 15, 2008, 122 Stat. 2553, provided that: ''The amendments made by this subsection [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2010.''

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–173, title I, §101(a)(2)(B), Dec. 29, 2007, 121 Stat. 2494, provided that:

''(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 29, 2007].

''(ii) SPECIAL RULE FOR COORDINATION WITH CONSOLIDATED APPROPRIATIONS ACT, 2008.—If the date of the enactment of the Consolidated Appropriations Act, 2008 [Dec. 26, 2007], occurs on or after the date described in clause (i), the amendments made by subparagraph (A) shall be deemed to be made on the day after the effective date of sections 225(c)(1) [121 Stat. 2190] and 524 [amending this section] of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).''

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5112(c) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title VI, §601(b)(2), Dec. 8, 2003, 117 Stat. 2301, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to computations of the sustainable growth rate for years beginning with 2003.''

Pub. L. 108–173, title VI, §611(e), Dec. 8, 2003, 117 Stat. 2304, provided that: ''The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.] begins on or after such date.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable with respect to screening mammographies furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §104(c)] of Pub. L. 106–554, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that: ''The amendments made by this section [amending this section and sections 1395b–6 and 1395*l* of this title] shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001.''

Amendment by section 1000(a)(6) [title III, §321(k)(5)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b)(2)(B), (C) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33 set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4102(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4103(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4104(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4105(a)(2) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Amendment by section 4106(b) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4502(a)(2), Aug. 5, 1997, 111 Stat. 433, provided that: ''The amendment made by this subsection [amending this section] shall apply to the update for years beginning with 1999.''

Pub. L. 105–33, title IV, §4504(b), Aug. 5, 1997, 111 Stat. 435, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to servics furnished on or after January 1, 1998.''

Amendment by section 4714(b)(2) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 123(a) of Pub. L. 103–432 applicable to services furnished on or after Oct. 31, 1994, but inapplicable to services of nonparticipating supplier or other person furnished before Jan. 1, 1995, see section 123(f)(1) of Pub. L. 103–432, set out as a note under section 1395*l* of this title.

Pub. L. 103–432, title I, §123(f)(5), Oct. 31, 1994, 108 Stat. 4413, provided that: ''The amendment made by subsection (d) [amending this section] shall apply to reports for years beginning with 1995.''

Amendment by section 126(b)(6), (g)(2)(B), (5)–(7), (10)(A) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 126(i) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13511(b), Aug. 10, 1993, 107 Stat. 581, provided that: ''The amendments made by this section [amending this section] shall apply to servics furnished on or after January 1, 1994; except that amendment made by subsection (a)(2) shall not apply—

''(1) to volume performance standard rates of increase established under section 1848(f) of the Social Security Act [42 U.S.C. 1395w–4(f)] for fiscal years before fiscal year 1994, and

''(2) to adjustment in updates in the conversion factors for physicians' services under section 1848(d)(3)(B) of such Act for physicians' services to be furnished in calendar years before 1996.''

Pub. L. 103–66, title XIII, §13514(d), Aug. 10, 1993, 107 Stat. 583, provided that: ''The amendments made by this section [amending this section] shall apply to servics furnished on or after January 1, 1994.''

Amendment by section 13515(a)(1) of Pub. L. 103–66 applicable to services furnished on or after Jan. 1, 1994, see section 13515(d) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, § 13517(c), Aug. 10, 1993, 107 Stat. 586, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13518(c), Aug. 10, 1993, 107 Stat. 586, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1995.''

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4102(b), (g)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4102(i)(1) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Amendment by section 4104(b)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4104(d) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

Amendment by section 4106(b)(1) of Pub. L. 101–508 applicable to services furnished after 1991, see section 4106(d)(2) of Pub. L. 101–508, set out as a note under section 1395u of this title.

Pub. L. 101–508, title IV, § 4107(a)(2), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, § 126(d)(2), Oct. 31, 1994, 108 Stat. 4415, provided that: ''Section 1848(i)(2) of the Social Security Act [42 U.S.C. 1395w–4(i)(2)], as added by the amendment made by paragraph (1), shall apply to services furnished in 1991 in the same manner as it applies to services furnished after 1991. In applying the previous sentence, the prevailing charge shall be substituted for the fee schedule amount. In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year).''

Pub. L. 101–508, title IV, § 4107(c), Nov. 5, 1990, 104 Stat. 1388–63, as amended by Pub. L. 103–432, title I, § 126(d)(1), Oct. 31, 1994, 108 Stat. 4415, provided that: ''The amendment made by subsection (a)(1) [amending this section] shall apply with respect to services furnished on or after January 1, 1992.''

Pub. L. 101–508, title IV, § 4109(b), Nov. 5, 1990, 104 Stat. 1388–63, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1992. In applying section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that section 1848(b)(3) of such Act (as added by the amendment made by subsection (a)) had applied to physicians' services furnished during 1991.''

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

TERMINATION OF REPORTING REQUIREMENTS

For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 8 on page 94 identifies a reporting provision which, as subsequently amended, is contained in subsec. (g)(6)(B) of this section and in which item 9 on page 94 identifies a reporting provision which is contained in subsec. (g)(7)(B) of this section), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.

MORATORIUM ON PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE OF THE ADD ON CODE FOR INHERENTLY COMPLEX EVALUATION AND MANAGEMENT VISITS

Pub. L. 116–260, div. CC, title I, § 113, Dec. 27, 2020, 134 Stat. 2947, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services may not, prior to January 1, 2024, make payment under the fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code), as described in section II.F. of the final rule filed by the Secretary with the Office of the Federal Register for public inspection on December 2, 2020, and entitled 'Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19'.

''(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by interim final rule, program instruction, or otherwise.''

IMPLEMENTATION

Pub. L. 114–115, § 4(c), Dec. 28, 2015, 129 Stat. 3133, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the provisions of, and the amendments made by, subsections (a) and (b) [amending this section and section 1395ww of this title] by program instruction, such as through information on the Internet website of the Centers for Medicare & Medicaid Services.''

EDUCATION AND OUTREACH CAMPAIGN

Pub. L. 114–10, title I, § 103(b)(1), Apr. 16, 2015, 129 Stat. 132, provided that:

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act [42 U.S.C. 1395w–4(b)(8)], as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

''(B) REQUIREMENTS.—Such campaign shall—

''(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

''(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.''

RECOMMENDATIONS FOR ACHIEVING WIDESPREAD ELECTRONIC HEALTH RECORD (EHR) INTEROPERABILITY

Pub. L. 114–10, title I, § 106(b)(1), Apr. 16, 2015, 129 Stat. 138, provided that:

''(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018.

''(B) DEFINITIONS.—In this paragraph:

''(i) WIDESPREAD INTEROPERABILITY.—The term 'widespread interoperability' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

''(ii) INTEROPERABILITY.—The term 'interoperability' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

''(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2016, and in consultation with stakeholders, the Secretary [of Health and Human Services] shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

''(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2018, then the Secretary shall submit to Congress a report, by not later than December 31, 2019, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

''(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

''(ii) for criteria for decertifying certified EHR technology products.''

[As used in section 106(b)(1) of Pub. L. 114–10, set out above, ''certified EHR technology'' has the meaning given in 42 U.S.C. 1395w–4(*o*)(4); ''meaningful EHR user'' has the meaning given under the ''Medicare EHR incentive programs'', which term means the incentive programs under 42 U.S.C. 1395f(*l*)(3), 42 U.S.C. 1395w–4(*o*), 42 U.S.C. 1395w–23(*l*), (m), and 42 U.S.C. 1395ww(n); and ''Medicaid EHR incentive program'' means the incentive program under 42 U.S.C. 1396b(a)(3)(F), (t). See Pub. L. 114–10, title I, § 106(b)(4), Apr. 16, 2015, 129 Stat. 140.]

DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY

Pub. L. 113–93, title II, § 220(i), Apr. 1, 2014, 128 Stat. 1076, which required the Secretary of Health and Human Services to make publicly available information used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register on Nov. 16, 2012, was repealed by Pub. L. 114–113, div. O, title V, § 502(a)(2)(C), Dec. 18, 2015, 129 Stat. 3019.

CENTERS FOR MEDICARE & MEDICAID SERVICES TO STUDY REFORM OF PHYSICIAN REIMBURSEMENTS

Pub. L. 113–67, div. B, § 1002, Dec. 26, 2013, 127 Stat. 1195, provided that: ''In order to support the provision of quality care for our nation's seniors, Congress finds it appropriate to reform physician reimbursements under the Medicare program. SGR reform legislation provides such an opportunity, but not until next year. In order to facilitate such reform, Congress finds that the Centers for Medicare & Medicaid Services should continue to focus its efforts on the following areas:

''(1) SIMPLIFY AND REDUCE ADMINISTRATIVE BURDEN ON PHYSICIANS.—The application and assessment of measures and other activities under SGR reform should be facilitated by the Centers for Medicare and Medicaid Services (CMS) in a way that accounts for the administrative burden such measurement places on physicians. Therefore, the Congress encourages CMS to identify and implement, to the extent practicable, mechanisms to ensure that the application and assessment of measures be coordinated across programs.

''(2) TIMELY FEEDBACK FOR PHYSICIANS.—In order for measure and assessment programs to encourage the highest quality care for Medicare seniors, the Congress finds it critical that CMS provide physicians with feedback on performance in as close to real time as possible. Such timely feedback will ensure that physicians can excel under a system of meaningful measurement.

''(3) ENCOURAGE DEVELOPMENT OF NEW MODELS.—There is great need to test alternatives to Fee-For-Service reimbursement in the Medicare program. One option is the promotion and adoption of new models of care for physicians. To date, there has been significant development and testing of models for primary care. Congress supports these efforts and encourages them to continue in the future. Congress also encourages the development and testing of models of specialty care.''

IMPLEMENTATION OF 2010 AMENDMENT

Pub. L. 111–157, § 5(c), Apr. 15, 2010, 124 Stat. 1118, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1396b of this title and enacting provisions set out as a note under this section] by program instruction or otherwise.''

Pub. L. 111–148, title III, § 3111(a)(2), Mar. 23, 2010, 124 Stat. 421, provided that: ''Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) [amending this section] by program instruction or otherwise.''

Pub. L. 111–148, title III, § 3134(b)(1), Mar. 23, 2010, 124 Stat. 435, provided that:

''(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section [amending this section and section 1395ee of this title and repealing provisions set out as a note under this section] or the amendment made by this section.

''(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of [section] 1848(c)(2) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(K), (L)], as added by subsection (a), by program instruction or otherwise.

''(C) [Repealed section 4505(d) of Pub. L. 105–33, formerly set out below.]

''(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.''

AUTHORITY TO INCORPORATE MAINTENANCE OF CERTIFICATION PROGRAMS INTO MEASURES OF QUALITY OF CARE

Pub. L. 111–148, title III, § 3002(c)(3), as added by Pub. L. 111–148, title X, § 10327(b), Mar. 23, 2010, 124 Stat. 963, provided that: ''For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).''

NO CHANGE IN BILLING

Pub. L. 110–275, title I, §131(b)(4)(B), July 15, 2008, 122 Stat. 2525, provided that: ''Nothing in the amendment made by subparagraph (A) [amending this section] shall be construed to change the way in which billing for audiology services (as defined in section 1861(*ll*)(2) of the Social Security Act (42 U.S.C. 1395x(*ll*)(2))) occurs under title XVIII of such Act [42 U.S.C. 1395 et seq.] as of July 1, 2008.''

NO EFFECT ON INCENTIVE PAYMENTS FOR 2007 OR 2008

Pub. L. 110–275, title I, §131(b)(6), July 15, 2008, 122 Stat. 2526, provided that: ''Nothing in the amendments made by this subsection or section 132 [amending this section] shall affect the operation of the provisions of section 1848(m) of the Social Security Act [42 U.S.C. 1395w–4(m)], as redesignated and amended by such subsection and section, with respect to 2007 or 2008.''

ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES

Pub. L. 110–275, title I, §138, July 15, 2008, 122 Stat. 2541, as amended by Pub. L. 111–148, title III, §3107, Mar. 23, 2010, 124 Stat. 418; Pub. L. 111–309, title I, §107, Dec. 15, 2010, 124 Stat. 3288; Pub. L. 112–78, title III, §307, Dec. 23, 2011, 125 Stat. 1285, provided that:

''(a) PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the period beginning on July 1, 2008, and ending on February 29, 2012, the Secretary of Health and Human Services shall increase the fee schedule otherwise applicable for specified services by 5 percent.

''(2) NONAPPLICATION OF BUDGET-NEUTRALITY.—The budget-neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply to the adjustments described in paragraph (1).

''(b) DEFINITION OF SPECIFIED SERVICES.—In this section, the term 'specified services' means procedure codes for services in the categories of the Health Care Common Procedure Coding System, established by the Secretary of Health and Human Services under section 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w–4(c)(5)), as of July 1, 2007, and as subsequently modified by the Secretary, consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings, but only with respect to such services in such categories that are in the subcategories of services which are—

''(1) insight oriented, behavior modifying, or supportive psychotherapy; or

''(2) interactive psychotherapy.

''(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.''

TRANSFER OF FUNDS TO PART B TRUST FUND

Pub. L. 110–173, title I, §101(a)(2)(C), Dec. 29, 2007, 121 Stat. 2494, provided that: ''Amounts that would have been available to the Physician Assistance and Quality Initiative Fund under section 1848(*l*)(2) of the Social Security Act (42 U.S.C. 1395w–4(*l*)(2)) for payment with respect to physicians' services furnished prior to January 1, 2013, but for the amendments made by subparagraph (A) [amending this section], shall be deposited into, and made available for expenditures from, the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).''

TRANSITIONAL BONUS INCENTIVE PAYMENTS FOR QUALITY REPORTING IN 2007 AND 2008

Pub. L. 109–432, div. B, title I, §101(c), Dec. 20, 2006, 120 Stat. 2977, as amended, formerly set out as a note under this section, was transferred to subsec. (m) of this section.

TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL

Pub. L. 108–173, title III, §303(a)(2), Dec. 8, 2003, 117 Stat. 2236, provided that: ''The Secretary [of Health and Human Services] shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments made by paragraph (1) [amending this section].''

PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE

Pub. L. 108–173, title III, §303(a)(3), Dec. 8, 2003, 117 Stat. 2236, provided that:

''(A) REVIEW OF POLICY.—The Secretary [of Health and Human Services] shall review the policy, as in effect on October 1, 2003, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 drug or biological to an individual on a single day through the push technique.

''(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy as the Secretary determines to be appropriate.

''(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).''

TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, §303(a)(4), Dec. 8, 2003, 117 Stat. 2237, provided that:

''(A) IN GENERAL.—In order to provide for a transition during 2004 and 2005 to the payment system established under the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395u, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under section 1395u of this title], in the case of physicians' services consisting of drug administration services described in subparagraph (H)(iv) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), furnished on or after January 1, 2004, and before January 1, 2006, in addition to the amount determined under the fee schedule under section 1848(b) of such Act (42 U.S.C. 1395w–4(b)) there also shall be paid to the physician from the Federal Supplementary Medical Insurance Trust Fund an amount equal to the applicable percentage specified in subparagraph (B) of such fee schedule amount for the services so determined.

''(B) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for services furnished—

''(i) during 2004, is 32 percent; and

''(ii) during 2005, is 3 percent.''

MEDPAC REVIEW AND REPORTS; SECRETARIAL RESPONSE

Pub. L. 108–173, title III, §303(a)(5), Dec. 8, 2003, 117 Stat. 2237, provided that:

''(A) REVIEW.—The Medicare Payment Advisory Commission shall review the payment changes made under this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395u, 1395x, 1395y, and 1396r–8 of this title, enacting provisions set out as notes under this section and sections 1395u, 1395w–3a, and 1395w–3b of this title, and repealing provisions set out as a note under section 1395u of this title] insofar as they affect payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]—

''(i) for items and services furnished by oncologists; and

''(ii) for drug administration services furnished by other specialists.

''(B) OTHER MATTERS STUDIED.—In conducting the review under subparagraph (A), the Commission shall also review such changes as they affect—

''(i) the quality of care furnished to individuals enrolled under part B and the satisfaction of such individuals with that care;

''(ii) the adequacy of reimbursement as applied in, and the availability in, different geographic areas and to different physician practice sizes; and

''(iii) the impact on physician practices.

''(C) REPORTS.—The Commission shall submit to the Secretary [of Health and Human Services] and Congress—

''(i) not later than January 1, 2006, a report on the review conducted under subparagraph (A)(i); and

''(ii) not later than January 1, 2007, a report on the review conducted under subparagraph (A)(ii).

Each such report may include such recommendations regarding further adjustments in such payments as the Commission deems appropriate.

''(D) SECRETARIAL RESPONSE.—As part of the rulemaking with respect to payment for physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for 2007, the Secretary may make appropriate adjustments to payment for items and services described in subparagraph (A)(i), taking into account the report submitted under such subparagraph (C)(i).''

MULTIPLE CHEMOTHERAPY AGENTS, OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL, AND TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, § 303(g)(3), Dec. 8, 2003, 117 Stat. 2253, provided that: ''There shall be no administrative or judicial review under section 1869 [probably means section 1869 of the Social Security Act, 42 U.S.C. 1395ff], section 1878 [probably means section 1878 of the Social Security Act, 42 U.S.C. 1395*oo*], or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) through (4) of subsection (a) [enacting provisions set out as notes under this section].''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title IV, § 413(c), Dec. 8, 2003, 117 Stat. 2277, provided that:

''(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

''(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

''(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

''(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

''(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act [42 U.S.C. 1395w–4(e)(1)(E)], as added by section 412, on physician location and retention in areas affected by such adjustment, taking into account—

''(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

''(ii) the mobility of physicians, including specialists, over the last decade.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).''

AMENDMENTS NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION

Pub. L. 109–171, title V, § 5104(b), Feb. 8, 2006, 120 Stat. 41, provided that: ''The amendments made by subsection (a) [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).''

Pub. L. 108–173, title VI, § 601(a)(3), Dec. 8, 2003, 117 Stat. 2301, provided that: ''The amendments made by this subsection [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).''

COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA

Pub. L. 108–173, title VI, § 605, Dec. 8, 2003, 117 Stat. 2302, provided that:

''(a) IN GENERAL.—Not later than January 1, 2005, the Secretary [of Health and Human Services] shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(i)).

''(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

''(c) REPORT AND RECOMMENDATIONS.—

''(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the

review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

''(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule.''

MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §606, Dec. 8, 2003, 117 Stat. 2302, provided that:

''(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

''(1) The effect of such refinements on payment for physicians' services.

''(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

''(3) The appropriateness of the amount of compensation by reason of such refinements.

''(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

''(5) The effect of such refinements on physician participation under the medicare program.

''(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B [42 U.S.C. 1395j et seq.] of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

''(1) An analysis of recent and historic growth in the components that the Secretary [of Health and Human Services] includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

''(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

''(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

''(4) An examination of the impact on volume of demographic changes.

''(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

''(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.''

MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS

Pub. L. 108–173, title VI, §644, Dec. 8, 2003, 117 Stat. 2323, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

''(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.''

REPORT ON PHYSICIAN COMPENSATION

Pub. L. 108–173, title IX, §953(a)(2), Dec. 8, 2003, 117 Stat. 2428, provided that: ''Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).''

TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE

Pub. L. 106–554, §1(a)(6) [title V, §542], Dec. 21, 2000, 114 Stat. 2763, 2763A–550, as amended by Pub. L. 108–173, title VII, §732, Dec. 8, 2003, 117 Stat. 2352; Pub. L. 109–432, div. B, title I, §104, Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–173, title I, §104, Dec. 29, 2007, 121 Stat. 2495; Pub. L. 110–275, title I, §136, July 15, 2008, 122 Stat. 2540; Pub. L. 111–148, title III, §3104, Mar. 23, 2010, 124 Stat. 417; Pub. L. 111–309, title I, §105, Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, §305, Dec. 23, 2011, 125 Stat. 1284; Pub. L. 112–96, title III, §3006, Feb. 22, 2012, 126 Stat. 189, provided that:

''(a) IN GENERAL.—When an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary of Health and Human Services shall treat such component as a service for which payment shall be made to the laboratory under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of such Act (42 U.S.C. 1395*l*(t)).

''(b) DEFINITIONS.—For purposes of this section:

''(1) COVERED HOSPITAL.—The term 'covered hospital' means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a medicare carrier (that has a contract with the Secretary under section 1842 of the Social Security Act, 42 U.S.C. 1395u) and not to such hospital.

''(2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who—

''(A) is entitled to benefits under part A, or enrolled under part B, or both, of such title [42 U.S.C. 1395c et seq., 1395j et seq.]; and

''(B) is not enrolled in any of the following:

''(i) A Medicare+Choice plan under part C of such title [42 U.S.C. 1395w–21 et seq.].

''(ii) A plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm).

''(iii) A program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee).

''(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) [101 Stat. 1330–65].

''(c) EFFECTIVE DATE.—This section shall apply to services furnished during the 2-year period beginning on January 1, 2001, and for services furnished during 2005, 2006, 2007, 2008, 2009, 2010, 2011, and the first six months of 2012.

''(d) GAO REPORT.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study of the effects of the previous provisions of this section on hospitals and laboratories and access of fee-for-service medicare beneficiaries to the technical component of physician pathology services.

''(2) REPORT.—Not later than April 1, 2002, the Comptroller General shall submit to Congress a report on such study. The report shall include recommendations about whether such provisions should be extended after the end of the period specified in subsection (c) for either or both inpatient and outpatient hospital services, and whether the provisions should be extended to other hospitals.''

ONE-TIME PUBLICATION OF INFORMATION ON TRANSITION

Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 211(a)(2)(C)], Nov. 29, 1999, 113 Stat. 1536, 1501A–347, provided that: ''The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section [Nov. 29, 1999], the Secretary's determination, based upon the best available data, of—

''(i) the allowed expenditures under subclauses (I) and (II) of subsection (d)(4)(C)(ii) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

''(ii) the estimated actual expenditures described in subsection (d) of such section for 1999; and

''(iii) the sustainable growth rate under subsection (f) of such section for 2000.''

USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES

Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 212], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that Department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

''(b) PUBLICATION OF INFORMATION.—The Secretary shall include, in the publication of the estimated and final updates under section 1848(c) of such Act (42 U.S.C. 1395w–4(c)) for payments for 2001 and for 2002, a description of the process established under subsection (a) for the use of external data in making adjustments in relative value units and the extent to which the Secretary has used such external data in making such adjustments for each such year, particularly in cases in which the data otherwise used are inadequate because such data are not based upon a large enough sample size to be statistically reliable.''

CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS

Pub. L. 105–33, title IV, § 4105(a)(3), Aug. 5, 1997, 111 Stat. 367, provided that: ''In establishing payment amounts under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes.''

DEVELOPMENT OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS

Pub. L. 105–33, title IV, § 4505(d), Aug. 5, 1997, 111 Stat. 435, which required the Secretary of Health and Human Services to develop new resource-based relative value units in accordance with certain procedures, transmit a report by Mar. 1, 1998, to certain Congressional Committees, publish a notice of proposed rulemaking with the new relative value units on or before May 1, 1998, and allow public comment, was repealed by Pub. L. 111–148, title III, § 3134(b)(1)(C), Mar. 23, 2010, 124 Stat. 435.

APPLICATION OF CERTAIN BUDGET NEUTRALITY PROVISIONS

Pub. L. 105–33, title IV, § 4505(f)(2), Aug. 5, 1997, 111 Stat. 437, provided that: ''In implementing the amendment made by paragraph (1)(A)(ii) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.''

DEVELOPMENT OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES

Pub. L. 103–432, title I, § 121(a), Oct. 31, 1994, 108 Stat. 4408, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1998 a resource-based system for determining practice expense relative value units for each physicians' service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

''(2) REPORT.—The Secretary shall transmit a report by June 30, 1996, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.''

APPLICATION OF SUBSECTION (c)(2)(B)(ii)(II), (iii)

Pub. L. 103–432, title I, § 121(b)(3), Oct. 31, 1994, 108 Stat. 4409, provided that: ''In implementing the amendment made by paragraph (1)(C) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(B)(ii)(II), (iii)] shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.''

REPORT ON REVIEW PROCESS

Pub. L. 103–432, title I, § 122(c), Oct. 31, 1994, 108 Stat. 4409, provided that not later than 1 year after Oct. 31,

1994, Secretary of Health and Human Services was to study and report to Congress on data necessary to review and revise indices established under subsec. (e)(1)(A) of this section, any limitations on availability of data necessary to review and revise such indices at least every three years, ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years, and costs of developing more accurate and timely data.

RELATIVE VALUE FOR PEDIATRIC SERVICES

Pub. L. 103–432, title I, §124(a), Oct. 31, 1994, 108 Stat. 4413, provided that: ''The Secretary of Health and Human Services shall fully develop, by not later than July 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act [42 U.S.C. 1395w–4(c)]. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values.''

BUDGET NEUTRALITY ADJUSTMENT

For provisions requiring reduction of relative values established under subsec. (c) of this section and amounts determined under subsec. (a)(2)(B)(ii)(I) of this section for 1994 (to be applied for that year and subsequent years) in order to assure that the amendments to this section and section 1395u of this title by section 13515(a) of Pub. L. 103–66 will not result in expenditures under this part that exceed the amount of such expenditures that would have been made if such amendments had not been made, see section 13515(b) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, §13518(b), Aug. 10, 1993, 107 Stat. 586, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the amendment made by subsection (a) [amending this section] in a manner to assure that such amendment will result in expenditures under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in 1995 for services described in such amendment that shall be equal to the amount of expenditures for such services that would have been made if such amendment had not been made.''

ANCILLARY POLICIES; ADJUSTMENT FOR INDEPENDENT LABORATORIES FURNISHING PHYSICIAN PATHOLOGY SERVICES

Pub. L. 101–508, title IV, §4104(c), Nov. 5, 1990, 104 Stat. 1388–59, provided that: ''The Secretary of Health and Human Services, in establishing ancillary policies under section 1848(c)(3) of the Social Security Act [42 U.S.C. 1395w–4(c)(3)], shall consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from an attending or consulting physician's office.''

COMPUTATION OF CONVERSION FACTOR FOR 1992

Pub. L. 101–508, title IV, §4105(b)(2), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(A)(i), Oct. 31, 1994, 108 Stat. 4415, provided that: ''In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act for 1992 [42 U.S.C. 1395w–4(d)(1)(B)], the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendment made by this subsection [amending section 1395u of this title] did not apply.''

Pub. L. 101–508, title IV, §4106(c), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, §126(g)(3), Oct. 31, 1994, 108 Stat. 4416, provided that: ''In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendments made by this section [amending this section, section 1395u of this title, and provisions set out as a note under section 1395u of this title] (notwithstanding subsection (d) [set out as an Effective Date of 1990 Amendment note under section 1395u of this title]) applied to all services furnished during such year.''

PUBLICATION OF PERFORMANCE STANDARD RATES

Pub. L. 101–508, title IV, §4105(d), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(C), Oct. 31, 1994, 108 Stat. 4416, provided that: ''Not later than 45 days after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services, based on the most recent data available, shall estimate and publish in the Federal Register the performance standard rates of increase specified in section 1848(f)(2)(C) of the Social Security Act [42 U.S.C. 1395w–4(f)(2)(C)] for fiscal year 1991.''

STUDY OF REGIONAL VARIATIONS IN IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM

Pub. L. 101–508, title IV, §4115, Nov. 5, 1990, 104 Stat. 1388–65, provided that:

''(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

''(1) factors that may explain geographic variations in Medicare reasonable charges for physicians' services that are not attributable to variations in physician practice costs (including the supply of physicians in an area and area variations in the mix of services furnished);

''(2) the extent to which the geographic practice cost indices applied under the fee schedule established under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] accurately reflect variations in practice costs and malpractice costs (and alternative sources of information upon which to base such indices);

''(3) the impact of the transition to a national, resource-based fee schedule for physicians' services under Medicare on access to physicians' services in areas that experience a disproportionately large reduction in payments for physicians' services under the fee schedule by reason of such variations; and

''(4) appropriate adjustments or modifications in the transition to, or manner of determining payments under, the fee schedule established under section 1848 of the Social Security Act, to compensate for such variations and ensure continued access to physicians' services for Medicare beneficiaries in such areas.

''(b) REPORT.—By not later than July 1, 1992, the Secretary shall submit to Congress a report on the study conducted under subsection (a).''

STATEWIDE FEE SCHEDULE AREAS FOR PHYSICIANS' SERVICES

Pub. L. 101–508, title IV, §4117, Nov. 5, 1990, 104 Stat. 1388–65, as amended by Pub. L. 103–432, title I, §126(f), Oct. 31, 1994, 108 Stat. 4415, provided that: ''Notwithstanding section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)), in the case of the States of Nebraska and Oklahoma the Secretary of Health and Human Services (Secretary) shall treat the State as a single fee schedule area for purposes of determining—

''(1) the adjusted historical payment basis (as defined in section 1848(a)(2)(D) of such Act (42 U.S.C. 1395w–4(a)(2)(D))), and

''(2) the fee schedule amount (as referred to in section 1848(a) (42 U.S.C. 1395w–4(a)) of such Act),

for physicians' services (as defined in section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3))) furnished on or after January 1, 1992.''

STUDIES

Pub. L. 101–239, title VI, § 6102(d), Dec. 19, 1989, 103 Stat. 2185, as amended by Pub. L. 103–432, title I, § 126(h)(1), Oct. 31, 1994, 108 Stat. 4416; Pub. L. 105–362, title VI, § 601(b)(5), Nov. 10, 1998, 112 Stat. 3286, provided for various studies and reports as follows: (1) directed Comptroller General to conduct study of alternative payment methodology for malpractice component for physicians' services, and to submit report to Congress by not later than Apr. 1, 1991; (2) directed Secretary of Health and Human Services to conduct study of how payments under this section may affect payments to eligible organizations with risk-sharing contracts under section 1395mm of this title, and to submit report to Congress by not later than Apr. 1, 1990; (3) directed Secretary to conduct study of volume performance standard rates of increase for services furnished by geography, specialty, and type of service, and to submit report with appropriate recommendations to Congress by not later than July 1, 1990; (4) directed Physician Payment Review Commission to conduct study of payment for practice and malpractice expenses, including appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for such procedures using a consensus panel and other appropriate methodologies, and to submit report and recommendations to Congress by not later than July 1, 1991; (5) directed Physician Payment Review Commission to conduct study of feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians' services under this part, and to submit report to Congress by not later than July 1, 1991; (6) directed Physician Payment Review Commission to conduct study of payment for nonphysician providers of medicare services, including physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under medicare program on a fee-for-service basis, and to submit report to Congress by not later than July 1, 1991; (7) directed Physician Payment Review Commission to conduct study of physician fees under State medicaid programs established under subchapter XIX of this chapter, and to submit report with recommendations to Congress by no later than July 1, 1991; and (8) directed Comptroller General to conduct study of effect of anti-trust laws on ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization, and to submit report to Congress by no later than July 1, 1991.

DISTRIBUTION OF MODEL FEE SCHEDULE

Pub. L. 101–239, title VI, § 6102(e)(11), Dec. 19, 1989, 103 Stat. 2188, as amended by Pub. L. 101–508, title IV, § 4118(f)(2)(E), Nov. 5, 1990, 104 Stat. 1388–70, provided that: ''By September 1, 1990, the Secretary of Health and Human Services shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act [42 U.S.C. 1395w–4]. The Model Fee Schedule shall include as many services as the Secretary of Health and Human Services concludes can be assigned valid relative values. The Secretary of Health and Human Services shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.''

§ 1395w–5. Public reporting of performance information

(a) In general

(1) Development

Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) Plan

Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) Other required considerations

In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) Ensuring patient privacy

The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections[1] 552 or 552a of title 5 with regard to the privacy of individually identifiable health information.

(d) Feedback from multi-stakeholder groups

The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act [42 U.S.C. 1395aaa(b)(7), 1395aaa–1], as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) Consideration of transition to value-based purchasing

In developing the plan under this[2] subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) Report to Congress

Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) Expansion

At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]) the information made available on such website.

(h) Financial incentives to encourage consumers to choose high quality providers

The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) Definitions

In this section:

(1) Eligible professional

The term ''eligible professional'' has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) Physician

The term ''physician'' has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) Physician Compare

The term ''Physician Compare'' means the Internet website developed under subsection (a)(1).

(4) Secretary

The term ''Secretary'' means the Secretary of Health and Human Services.

(Pub. L. 111–148, title X, §10331, Mar. 23, 2010, 124 Stat. 966.)

Editorial Notes

REFERENCES IN TEXT

Section 3014 of this Act, referred to in subsec. (d), is section 3014 of Pub. L. 111–148 which enacted section 1395aaa–1 of this title and amended section 1395aaa of this title.

Section 131 of the Medicare Improvements for Patients and Providers Act of 2008, referred to in subsec. (e), is section 131 of Pub. L. 110–275, 122 Stat. 2520, which amended section 1395w–4 of this title, enacted provisions set out as notes under section 1395w–4 of this title, and redesignated provisions formerly set out as a note under section 1395w–4 of this title as section 1395w–4(m).

The Social Security Act, referred to in subsecs. (g) and (h), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

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

§ 1395w–6. Empowering beneficiary choices through continued access to information on physicians' services

(a) In general

On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) Type and manner of information

The information made available under this section shall be similar to the type of informa-

[1] So in original. Probably should be ''section''.

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

tion in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such file is made available.

(c) Requirements

The information made available under this section shall include, at a minimum, the following:

(1) Information on the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(d) Searchability

The information made available under this section shall be searchable by at least the following:

(1) The specialty or type of the physician or other eligible professional.

(2) Characteristics of the services furnished, such as volume or groupings of services.

(3) The location of the physician or other eligible professional.

(e) Integration on physician compare

Beginning with 2016, the Secretary shall integrate the information made available under this section on Physician Compare.

(f) Definitions

In this section:

(1) Eligible professional; physician; Secretary

The terms ''eligible professional'', ''physician'', and ''Secretary'' have the meaning given such terms in section 1395w–5(i) of this title.

(2) Physician compare

The term ''Physician Compare'' means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

(Pub. L. 114–10, title I, §104, Apr. 16, 2015, 129 Stat. 132.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a) and (c)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part B of title XVIII of the Act is classified generally to this part. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Social Security Act which comprises this chapter.

PART C—MEDICARE+CHOICE PROGRAM

Editorial Notes

PRIOR PROVISIONS

A prior part C of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

§ 1395w–21. Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans (including regional plans)

(i) In general

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1395w–25(d) of this title), and regional or local preferred provider organization plans (including MA regional plans).

(ii) Specialized MA plans for special needs individuals

Specialized MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title) may be any type of coordinated care plan.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w–28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w–28(b)(2) of this title.

(3) Medicare+Choice eligible individual

In this subchapter, the term ''Medicare+Choice eligible individual'' means an individual who is entitled to benefits under part A and enrolled under part B.

(b) Special rules

(1) Residence requirement

(A) In general

Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) Continuation of enrollment permitted

Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) Continuation of enrollment permitted where service changed

Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) Special rule for certain individuals covered under FEHBP or eligible for veterans or military health benefits

(A) FEHBP

An individual who is enrolled in a health benefit plan under chapter 89 of title 5 is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA and DOD

The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10 or under chapter 17 of title 38.

(3) Limitation on eligibility of qualified medicare beneficiaries and other medicaid beneficiaries to enroll in an MSA plan

An individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), a qualified disabled and working individual (described in section 1396d(s) of this title), an individual described in section 1396a(a)(10)(E)(iii) of this title, or otherwise entitled to medicare cost-sharing under a State plan under subchapter XIX is not eligible to enroll in an MSA plan.

(4) Coverage under MSA plans

(A) In general

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) Evaluation

The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this subchapter.

(C) Reports

The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) Process for exercising choice

(1) In general

The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) Coordination through Medicare+Choice organizations

(A) Enrollment

Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) Disenrollment

Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to

terminate such election through the filing of an appropriate election form with the organization.

(3) Default

(A) Initial election

(i) In general

Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

(ii) Seamless continuation of coverage

The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing periods

An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(4) Deemed enrollment relating to converted reasonable cost reimbursement contracts

(A) In general

On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this subchapter through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1395mm(h)(5)(C)(iv) of this title) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA eligible individuals described

(i) Without prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1395w–132 of this title.

(ii) With prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) Applicable MA plan defined

In this paragraph, the term ''applicable MA plan'' means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA–PD plan; and

(ii) subparagraph (B)(ii), an MA–PD plan.

(D) Identification and notification of deemed individuals

Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) Providing information to promote informed choice

(1) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of notice

(A) Open season notification

At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) General information

The general information described in paragraph (3).

(ii) List of plans and comparison of plan options

A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) Additional information

Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1395b–2 of this title.

(B) Notifications required

(i) Notification to newly eligible Medicare Advantage eligible individuals

To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(ii) Notification related to certain deemed elections

The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1395mm(h)(5)(C)(iv) of this title to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this subchapter through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) Form

The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) Periodic updating

The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) General information

General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) Benefits under original medicare fee-for-service program option

A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) Election procedures

Information and instructions on how to exercise election options under this section.

(C) Rights

A general description of procedural rights (including grievance and appeals procedures)

of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1395w–22(b) of this title.

(D) Information on medigap and medicare select

A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1395ss of this title and provisions relating to medicare select policies described in section 1395ss(t) of this title.

(E) Potential for contract termination

The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) Catastrophic coverage and single deductible

In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) Information comparing plan options

Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) Benefits

The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) Premiums

(i) In general

The monthly amount of the premium charged to an individual.

(ii) Reductions

The reduction in part B premiums, if any.

(C) Service area

The service area of the plan.

(D) Quality and performance

To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) Supplemental benefits

Supplemental health care benefits, including any reductions in cost-sharing under section 1395w–22(a)(3) of this title and the terms and conditions (including premiums) for such benefits.

(5) Maintaining a toll-free number and Internet site

The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) Use of non-Federal entities

The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) Provision of information

A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) Coverage election periods

(1) Initial choice upon eligibility to make election if Medicare+Choice plans available to individual

If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may re-

ceive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) Open enrollment and disenrollment opportunities

Subject to paragraph (5)—

(A) Continuous open enrollment and disenrollment through 2005

At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) Continuous open enrollment and disenrollment for first 6 months during 2006

(i) In general

Subject to clause (ii), subparagraph (C)(iii),[1] and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) Annual 45-day period from 2011 through 2018 for disenrollment from MA plans to elect to receive benefits under the original Medicare fee-for-service program

Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011 and ending with 2018), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(D) Continuous open enrollment for institutionalized individuals

At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) Limited continuous open enrollment of original fee-for-service enrollees in medicare advantage non-prescription drug plans

(i) In general

On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA–PD plan.

(ii) Unenrolled fee-for-service individual defined

In this subparagraph, the term ''unenrolled fee-for-service individual'' means, with respect to a date, a Medicare Advantage eligible individual who—

(I) is receiving benefits under this subchapter through enrollment in the original medicare fee-for-service program under parts A and B;

(II) is not enrolled in an MA plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) Limitation of one change during the applicable period

An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) No effect on coverage under a prescription drug plan

Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) Special period for certain deemed elections

(i) In general

At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected dur-

[1] See References in Text note below.

ing an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(G) Continuous open enrollment and disenrollment for first 3 months in 2016 and subsequent years

(i) In general

Subject to clause (ii) and subparagraph (D)—

(I) in the case of an MA eligible individual who is enrolled in an MA plan, at any time during the first 3 months of a year (beginning with 2019); or

(II) in the case of an individual who first becomes an MA eligible individual during a year (beginning with 2019) and enrolls in an MA plan, during the first 3 months during such year in which the individual is an MA eligible individual;

such MA eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change during open enrollment period each year

An individual may change the election pursuant to clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(iii) Limited application to part D

Clauses (i) and (ii) of this subparagraph shall only apply with respect to changes in enrollment in a prescription drug plan under part D in the case of an individual who, previous to such change in enrollment, is enrolled in a Medicare Advantage plan.

(iv) Limitations on marketing

Pursuant to subsection (j), no unsolicited marketing or marketing materials may be sent to an individual described in clause (i) during the continuous open enrollment and disenrollment period established for the individual under such clause, notwithstanding marketing guidelines established by the Centers for Medicare & Medicaid Services.

(3) Annual, coordinated election period

(A) In general

Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) Annual, coordinated election period

For purposes of this section, the term ''annual, coordinated election period'' means—

(i) with respect to a year before 2002, the month of November before such year;

(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

(C) Medicare+Choice health information fairs

During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) Special information campaigns

During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1395mm of this title, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) Special election periods

Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for

which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) Special rules for MSA plans

Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) Open enrollment periods

Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) Effectiveness of elections and changes of elections

(1) During initial coverage election period

An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1395q of this title) in order to prevent retroactive coverage.

(2) During continuous open enrollment periods

An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) Annual, coordinated election period

An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B), other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) Other periods

An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) Guaranteed issue and renewal

(1) In general

Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) Priority

If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1395w–22(b) of this title, among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) Limitation on termination of election

(A) In general

Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) Basis for termination of election

A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1395w–26 of this title that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) Consequence of termination

(i) Terminations for cause

Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) Termination based on plan termination or service area reduction

Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

(D) Organization obligation with respect to election forms

Pursuant to a contract under section 1395w–27 of this title, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) Approval of marketing material and application forms

(1) Submission

No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) Review

The standards established under section 1395w–26 of this title shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) Deemed approval (1-stop shopping)

In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) Prohibition of certain marketing practices

Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1395w–26 of this title. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) Special treatment of marketing material following model marketing language

In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) Required inclusion of plan type in plan name

For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) Strengthening the ability of States to act in collaboration with the Secretary to address fraudulent or inappropriate marketing practices

(A) Appointment of agents and brokers

Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medi-

care Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) Compliance with State information requests

Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) Effect of election of Medicare+Choice plan option

(1) Payments to organizations

Subject to sections 1395w–22(a)(5), 1395w–23(a)(4), 1395w–23(g), 1395w–23(h), 1395ww(d)(11), 1395ww(h)(3)(D), and 1395w–23(m) of this title, payments under a contract with a Medicare+Choice organization under section 1395w–23(a) of this title with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) Only organization entitled to payment

Subject to sections 1395w–23(a)(4), 1395w–23(e), 1395w–23(g), 1395w–23(h), 1395w–27(f)(2), 1395w–27a(h), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(3) FFS payment for expenses for kidney acquisitions

Paragraphs (1) and (2) shall not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1395w–22(a)(1)(B)(i) of this title.

(j) Prohibited activities described and limitations on the conduct of certain other activities

(1) Prohibited activities described

The following prohibited activities are described in this paragraph:

(A) Unsolicited means of direct contact

Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) Cross-selling

The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) Meals

The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) Sales and marketing in health care settings and at educational events

Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) Limitations

The Secretary shall establish limitations with respect to at least the following:

(A) Scope of marketing appointments

The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.

(B) Co-branding

The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) Limitation of gifts to nominal dollar value

The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) Compensation

The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) Required training, annual retraining, and testing of agents, brokers, and other third parties

The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

(Aug. 14, 1935, ch. 531, title XVIII, §1851, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 275; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(A), title V, §§501(a)(1), (b), (c), 502(a), 519(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–378 to 1501A–380, 1501A–385; Pub. L. 106–554, §1(a)(6) [title VI,

§§ 606(a)(2)(C), 613(a), 619(a), 620(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558, 2763A–560, 2763A–563; Pub. L. 107–188, title V, § 532(a), (c)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, § 102(a), (c)(1), title II, §§ 221(a)(1), (d)(5), 222(*l*)(3)(A), (B), (D), (E), 231(a), 233(b), (d), 237(b)(2)(A), Dec. 8, 2003, 117 Stat. 2152, 2154, 2180, 2193, 2206, 2207, 2209, 2212; Pub. L. 109–432, div. B, title II, § 206(a), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, § 2, July 18, 2007, 121 Stat. 244; Pub. L. 110–275, title I, § 103(a)(1), (b)(1), (c)(1), (d)(1), July 15, 2008, 122 Stat. 2498–2501; Pub. L. 111–5, div. B, title IV, § 4102(d)(2), Feb. 17, 2009, 123 Stat. 486; Pub. L. 111–148, title III, §§ 3201(e)(2)(A)(i), 3204(a)(1), (b), Mar. 23, 2010, 124 Stat. 446, 456; Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040; Pub. L. 114–10, title II, § 209(b)(1)–(2)(B)(i), (3), (c), Apr. 16, 2015, 129 Stat. 147–150; Pub. L. 114–255, div. C, title XVII, §§ 17005, 17006(a)(1), (c)(2), Dec. 13, 2016, 130 Stat. 1333–1335.)

Editorial Notes

REFERENCES IN TEXT

Subsec. (e)(2)(C), referred to in subsec. (e)(2)(B)(i), was amended generally by section 3204(a)(1) of Pub. L. 111–148 and, as so amended, no longer contains a cl. (iii).

AMENDMENTS

2016—Subsec. (a)(3). Pub. L. 114–255, § 17006(a)(1), struck out subpar. (A) designation and heading, substituted ''In this subchapter,'' for ''In this subchapter, subject to subparagraph (B),'', and struck out subpar. (B), which provided a special rule for end-stage renal disease.

Subsec. (e)(2)(C). Pub. L. 114–255, § 17005(1), inserted ''from 2011 through 2018'' after ''45-day period'' in heading and ''and ending with 2018'' after ''beginning with 2011'' in text.

Subsec. (e)(2)(G). Pub. L. 114–255, § 17005(2), added subpar. (G).

Subsec. (i)(3). Pub. L. 114–255, § 17006(c)(2), added par. (3).

2015—Subsec. (a)(3)(B). Pub. L. 114–10, § 209(b)(3), inserted concluding provisions.

Subsec. (c)(1). Pub. L. 114–10, § 209(b)(1)(A), substituted ''Subject to paragraph (4), such elections'' for ''Such elections''.

Subsec. (c)(4). Pub. L. 114–10, § 209(b)(1)(B), added par. (4).

Subsec. (d)(2)(B). Pub. L. 114–10, § 209(c), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Pub. L. 114–10, § 209(c)(1), which directed the substitution of ''Notifications required'' for ''Notification to newly eligible medicare advantage eligible individuals'' in heading, was executed by making the substitution for ''Notification to newly eligible Medicare+Choice eligible individuals'' to reflect the probable intent of Congress.

Subsec. (e)(2)(F). Pub. L. 114–10, § 209(b)(2)(A), added subpar. (F).

Subsec. (e)(6)(A). Pub. L. 114–10, § 209(b)(2)(B)(i), substituted ''paragraph (1), during the period described in paragraph (2)(F),'' for ''paragraph (1),''.

2010—Subsec. (b)(1)(C). Pub. L. 111–148, § 3201(e)(2)(A)(i), which directed that subpar. (C) be struck out, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (e)(2)(C). Pub. L. 111–148, § 3204(a)(1), amended subpar. (C) generally. Prior to amendment, subpar. (C) related to continuous open enrollment and disenrollment for first 3 months of a year after 2006.

Subsec. (e)(3)(B)(iv). Pub. L. 111–148, § 3204(b)(2)(A), substituted '', 2008, 2009, and 2010'' for ''and succeeding years''.

Subsec. (e)(3)(B)(v). Pub. L. 111–148, § 3204(b)(1), (2)(B), (3), added cl. (v).

2009—Subsec. (i)(1). Pub. L. 111–5 substituted ''1395ww(h)(3)(D), and 1395w–23(m)'' for ''and 1395ww(h)(3)(D)''.

2008—Subsec. (h)(4)(A). Pub. L. 110–275, § 103(a)(1)(A)(i)(I)(aa), substituted '', subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates'' for ''cash or other monetary rebates''.

Subsec. (h)(4)(C). Pub. L. 110–275, § 103(a)(1)(A)(i)(I)(bb)–(III), added subpar. (C).

Subsec. (h)(4)(D). Pub. L. 110–275, § 103(b)(1)(A), added subpar. (D).

Subsec. (h)(6). Pub. L. 110–275, § 103(c)(1), added par. (6).

Subsec. (h)(7). Pub. L. 110–275, § 103(d)(1), added par. (7).

Subsec. (j). Pub. L. 110–275, § 103(a)(1)(A)(ii), added subsec. (j).

Subsec. (j)(2). Pub. L. 110–275, § 103(b)(1)(B), added par. (2).

2007—Subsec. (e)(2)(E)(i). Pub. L. 110–48, § 2(1), substituted ''the period beginning on January 1, 2007, and ending on July 31, 2007,'' for ''2007 or 2008''.

Subsec. (e)(2)(E)(iii). Pub. L. 110–48, § 2(2), substituted ''the applicable period'' for ''year'' in heading and ''the period described in such clause'' for ''the year'' in text.

2006—Subsec. (e)(2)(E). Pub. L. 109–432 added subpar. (E).

2003—Subsec. (a)(1). Pub. L. 108–173, § 102(c)(1)(A), (C), inserted ''(other than qualified prescription drug benefits)'' after ''benefits'' in introductory provisions and inserted concluding provisions.

Subsec. (a)(1)(B). Pub. L. 108–173, § 102(c)(1)(B), substituted comma for period at end.

Subsec. (a)(2)(A). Pub. L. 108–173, § 221(a)(1), substituted ''Coordinated care plans (including regional plans)'' for ''Coordinated care plans'' in heading, inserted cl. (i) designation and heading before ''Coordinated'', and inserted ''regional or local'' before ''preferred provider organization plans'' and ''(including MA regional plans)'' before period at end.

Subsec. (a)(2)(A)(ii). Pub. L. 108–173, § 231(a), added cl. (ii).

Subsec. (a)(3)(B)(ii). Pub. L. 108–173, § 222(*l*)(3)(D), made technical amendment to reference in original act which appears in text as reference to subsection (e)(4)(A) of this section.

Subsec. (b)(1)(B). Pub. L. 108–173, § 222(*l*)(3)(A)(i), (ii), substituted ''an MA local plan'' for ''a plan'' and ''benefits under the original medicare fee-for-service program option'' for ''basic benefits described in section 1395w–22(a)(1)(A) of this title''.

Subsec. (b)(1)(C). Pub. L. 108–173, § 222(*l*)(3)(A)(iii), substituted ''in an MA local plan'' for ''in a Medicare+Choice plan'' in introductory provisions.

Subsec. (b)(4). Pub. L. 108–173, § 233(b)(1), struck out ''on a demonstration basis'' after ''plans'' in heading.

Subsec. (b)(4)(A). Pub. L. 108–173, § 233(b)(2), struck out first sentence which read as follows: ''An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.''

Subsec. (b)(4)(C). Pub. L. 108–173, § 233(b)(3), struck out at end ''The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).''

Subsec. (d)(3)(F). Pub. L. 108–173, § 222(*l*)(3)(B)(i), added subpar. (F).

Subsec. (d)(4)(A)(ii). Pub. L. 108–173, § 222(*l*)(3)(B)(ii), inserted '', including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title'' after ''cost sharing''.

Subsec. (d)(4)(B)(i). Pub. L. 108–173, § 222(*l*)(3)(B)(iii), substituted ''monthly amount of the premium charged

to an individual'' for ''Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium''.

Subsec. (d)(4)(E). Pub. L. 108–173, §222(*l*)(3)(B)(iv), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.''

Subsec. (e)(1). Pub. L. 108–173, §102(a)(4), inserted at end ''If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.''

Subsec. (e)(2). Pub. L. 108–173, §102(a)(1)(A), substituted ''2005'' and ''2006'' for ''2004'' and ''2005'', respectively, wherever appearing.

Subsec. (e)(2)(B)(i). Pub. L. 108–173, §102(a)(6)(A), inserted '', subparagraph (C)(iii),'' after ''clause (ii)''.

Subsec. (e)(2)(C)(i). Pub. L. 108–173, §102(a)(6)(B), substituted ''clauses (ii) and (iii)'' for ''clause (ii)''.

Subsec. (e)(2)(C)(iii). Pub. L. 108–173, §102(a)(6)(C), added cl. (iii).

Subsec. (e)(3)(B). Pub. L. 108–173, §102(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year.''

Subsec. (e)(3)(C). Pub. L. 108–173, §102(a)(3)(A), inserted ''and during the period described in subparagraph (B)(iii)'' after ''(beginning with 1999)''.

Subsec. (e)(3)(D). Pub. L. 108–173, §102(a)(3)(B), in heading, substituted ''campaigns'' for ''campaign in 1998'' and, in text, inserted at end ''During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.''

Subsec. (e)(4). Pub. L. 108–173, §102(a)(1)(B), substituted ''2006'' for ''2005'' in two places.

Subsec. (e)(5)(A)(i). Pub. L. 108–173, §233(d)(1), inserted ''or'' at end.

Subsec. (e)(5)(A)(ii). Pub. L. 108–173, §233(d)(2), substituted semicolon for '', or''.

Subsec. (e)(5)(A)(iii). Pub. L. 108–173, §233(d)(3), struck out cl. (iii) which read as follows: ''the month of November 1998;''.

Subsec. (f)(1). Pub. L. 108–173, §222(*l*)(3)(E), substituted ''subsection (e)(1)'' for ''subsection (e)(1)(A)''.

Subsec. (f)(3). Pub. L. 108–173, §102(a)(5), inserted '', other than the period described in clause (iii) of such subsection'' after ''subsection (e)(3)(B)''.

Subsec. (i)(1). Pub. L. 108–173, §237(b)(2)(A)(i), inserted ''1395w–23(a)(4),'' after ''Subject to sections 1395w–22(a)(5),''.

Subsec. (i)(2). Pub. L. 108–173, §237(b)(2)(A)(ii), inserted ''1395w–23(a)(4),'' after ''Subject to sections''.

Pub. L. 108–173, §221(d)(5), inserted ''1395w–27a(h),'' after ''1395w–27(f)(2),''.

2002—Subsec. (e)(2)(A). Pub. L. 107–188, §532(a)(1), substituted ''through 2004'' for ''through 2001'' in heading and ''during the period beginning January 1, 1998, and ending on December 31, 2004'' for ''during 1998, 1999, 2000, and 2001'' in text.

Subsec. (e)(2)(B). Pub. L. 107–188, §532(a)(2), substituted ''during 2005'' for ''during 2002'' in heading.

Subsec. (e)(2)(B)(i), (C)(i). Pub. L. 107–188, §532(a)(3), substituted ''2005'' for ''2002'' wherever appearing.

Subsec. (e)(2)(D). Pub. L. 107–188, §532(a)(4), substituted ''2004'' for ''2001''.

Subsec. (e)(3)(B). Pub. L. 107–188, §532(c)(1)(A), substituted ''means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year'' for ''means, with respect to a calendar year (beginning with 2000), the month of November before such year''.

Subsec. (e)(4). Pub. L. 107–188, §532(a)(5), substituted ''2005'' for ''2002'' in introductory and concluding provisions.

Subsec. (e)(6)(A). Pub. L. 107–188, §532(c)(1)(B), substituted ''during the annual, coordinated election period under paragraph (3) for each subsequent year'' for ''each subsequent year (as provided in paragraph (3))''.

2000—Subsec. (a)(3)(B). Pub. L. 106–554, §1(a)(6) [title VI, §620(a)], substituted ''except that—'' and cls. (i) and (ii) for ''except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan.''

Subsec. (d)(4)(B). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(C)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (f)(2). Pub. L. 106–554, §1(a)(6) [title VI, §619(a)], struck out '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before period at end.

Subsec. (h)(1)(A). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(1)], inserted ''(or 10 days in the case described in paragraph (5))'' after ''45 days''.

Subsec. (h)(5). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(2)], added par. (5).

1999—Subsec. (b)(1)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(1)], inserted ''and except as provided in subparagraph (C)'' after ''may otherwise provide''.

Subsec. (b)(1)(C). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(2)], added subpar. (C).

Subsec. (e)(2)(B)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(1)], inserted ''and subparagraph (D)'' after ''clause (ii)''.

Subsec. (e)(2)(C)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(2)], inserted ''and subparagraph (D)'' after ''clause (ii)''.

Subsec. (e)(2)(D). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(3)], added subpar. (D).

Subsec. (e)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §519(a)], substituted ''During the fall season'' for ''In the month of November''.

Subsec. (e)(4)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(1)], added subpar. (A) and struck out former subpar. (A) which read as follows: ''the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;''.

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title V, §502(a)], inserted ''or change'' before ''is made'' and '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before the period at end.

Subsec. (i)(2). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(A)], struck out ''and'' after ''1395w–27(f)(2),''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. C, title XVII, §17006(a)(3), Dec. 13, 2016, 130 Stat. 1334, provided that: ''The amendments made by this subsection [amending this section and sections 1395w–22 and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2021.''

Pub. L. 114–255, div. C, title XVII, §17006(c)(3), Dec. 13, 2016, 130 Stat. 1335, provided that: ''The amendments made by this subsection [amending this section and section 1395w–22 of this title] shall apply with respect to plan years beginning on or after January 1, 2021.''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, provided that sections 3201 (amending this section and sections 1395w–23, 1395w–24, 1395w–27a, 1395w–29, and 1395eee of this title and enacting provisions set out as notes under this section and section 1395w–24 of this title) and 3203 (amending section 1395w–23 of this title) of Pub. L. 111–148, and the amendments made by such sections, were repealed, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3201(e)(2)(B), Mar. 23, 2010, 124 Stat. 447, which provided that amendments by section 3201(e)(2) of Pub. L. 111–148 (amending this section and sections 1395w–23 and 1395w–24 of this title) would take effect on Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3204(a)(2), Mar. 23, 2010, 124 Stat. 456, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to 2011 and succeeding years.''

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §103(a)(3), July 15, 2008, 122 Stat. 2499, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009.''

Pub. L. 110–275, title I, §103(b)(3), July 15, 2008, 122 Stat. 2500, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008).''

Pub. L. 110–275, title I, §103(d)(3), July 15, 2008, 122 Stat. 2501, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009.''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §102(c)(2), Dec. 8, 2003, 117 Stat. 2154, provided that: ''The amendments made by this subsection [amending this section] shall apply on and after January 1, 2006.''

Pub. L. 108–173, title II, §223(a), Dec. 8, 2003, 117 Stat. 2207, provided that: ''The amendments made by this subtitle [subtitle C (§§221–223) of title II of Pub. L. 108–173, enacting section 1395w–27a of this title and amending this section and sections 1395r, 1395s, 1395w, 1395w–22 to 1395w–24, 1395w–27, and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2006.''

Pub. L. 108–173, title II, §231(f)(1), Dec. 8, 2003, 117 Stat. 2208, provided that: ''The amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title] shall take effect upon the date of the enactment of this Act [Dec. 8, 2003].''

Amendment by section 237(b)(2)(A) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(c)(2), June 12, 2002, 116 Stat. 696, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to the annual, coordinated election period for years beginning with 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, §606(a)(2)(C)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §613(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to marketing material submitted on or after January 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title VI, §619(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–563, provided that: ''The amendment made by this section [amending this section] shall apply to elections and changes of coverage made on or after June 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title VI, §620(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–564, provided that:

''(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall apply to terminations and discontinuations occurring on or after the date of the enactment of this Act [Dec. 21, 2000].

''(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act [42 U.S.C. 1395w–21(a)(3)(B)(ii)] (as inserted by subsection (a)) shall also apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of the enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], as having discontinued enrollment in such a plan as of the date of the enactment of this Act.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(A)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §501(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–379, provided that:

''(1) The amendments made by subsection (a) [amending this section and section 1395ss of this title] apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].

''(2) The amendments made by subsection (c) [amending this section] apply to elections made on or after the date of the enactment of this Act [Nov. 29, 1999] with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.''

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §502(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that: ''The amendments made by this section [amending this section] apply to elections and changes of coverage made on or after January 1, 2000.''

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §519(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–385, provided that: ''The amendment made by subsection (a) [amending this section] first applies to campaigns conducted beginning in 2000.''

REGULATIONS

Pub. L. 108–173, title II, §223(b), Dec. 8, 2003, 117 Stat. 2207, provided that: ''The Secretary [of Health and Human Services] shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] to carry out the provisions of this Act [see Tables for classification].''

CONSTRUCTION

Pub. L. 108–173, title II, §221(b)(2), Dec. 8, 2003, 117 Stat. 2181, provided that: ''Nothing in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation.''

NO CUTS IN GUARANTEED BENEFITS

Pub. L. 111–148, title III, §3602, Mar. 23, 2010, 124 Stat. 538, provided that: ''Nothing in this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.''

IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM

Pub. L. 108–173, title II, §201, Dec. 8, 2003, 117 Stat. 2176, provided that:

''(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by this Act [see Tables for classification]).

''(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to 'Medicare+Choice' is deemed a reference to 'Medicare Advantage' and 'MA'.

''(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary [of Health and Human Services] shall provide for an appropriate transition in the use of the terms 'Medicare+Choice' and 'Medicare Advantage' (or 'MA') in reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to 'Medicare Advantage' or 'MA' shall be deemed to include a reference to 'Medicare+Choice'.''

REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS

Pub. L. 108–173, title II, §211(g), Dec. 8, 2003, 117 Stat. 2178, directed the Secretary of Health and Human Services to submit to Congress, not later than July 1, 2006, a report that described the impact of additional financing provided under Pub. L. 108–173 and other Acts on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING

Pub. L. 108–173, title II, §211(h), Dec. 8, 2003, 117 Stat. 2179, directed the Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under this part, to conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in subsection (a)(3) of this section, and to submit a report to Congress on such study not later than Dec. 31, 2004.

MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS

Pub. L. 108–173, title II, §221(a)(2), Dec. 8, 2003, 117 Stat. 2180, directed the Secretary of Health and Human Services not to permit the offering of a local preferred provider organization plan under this part during 2006 or 2007 in a service area unless such plan was offered under this part (including under a demonstration project under this part) in such area as of Dec. 31, 2005.

SPECIALIZED MA PLANS

Pub. L. 110–275, title I, §164(b), July 15, 2008, 122 Stat. 2571, provided that: ''During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals.''

Pub. L. 110–173, title I, §108(b), Dec. 29, 2007, 121 Stat. 2496, provided that:

''(1) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

''(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008.''

Pub. L. 108–173, title II, §231(d), Dec. 8, 2003, 117 Stat. 2208, provided that: ''In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act [42 U.S.C. 1395w–21(a)(2)(A)(ii)] (as added by subsection (a)) and section 1859(b)(6) of such Act [42 U.S.C. 1395w–28(b)(6)] (as added by subsection (b)), the Secretary [of Health and Human Services] may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals.''

Pub. L. 108–173, title II, §231(e), Dec. 8, 2003, 117 Stat. 2208, provided that: ''Not later than December 31, 2007, the Secretary [of Health and Human Services] shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title].''

MEDPAC STUDY ON CONSUMER COALITIONS

Pub. L. 106–554, §1(a)(6) [title I, §124], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, directed the Medicare Payment Advisory Commission to conduct a study examining the use of consumer coalitions in the marketing of Medicare+Choice plans under the medicare program under this subchapter and to submit a report on the study to Congress no later than 1 year after Dec. 21, 2000.

REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §551], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, directed the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, to submit to Congress, no later than Apr. 1, 2001, a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries.

REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, directed the

Medicare Payment Assessment Commission to submit to Congress, no later than 1 year after Nov. 29, 1999, a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

GAO AUDIT AND REPORTS ON PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 553(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

''(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

''(3) [(2)] REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a) [enacting provisions set out as a note under section 1395ss of this title], together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.''

ENROLLMENT TRANSITION RULE

Pub. L. 105–33, title IV, § 4002(c), Aug. 5, 1997, 111 Stat. 329, provided that: ''An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.] if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).''

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 105–33, title IV, § 4002(f)(2), Aug. 5, 1997, 111 Stat. 330, directed the Secretary of Health and Human Services to submit to Congress, no later than 6 months after Aug. 5, 1997, proposed technical and conforming amendments in the law as required by the provisions of chapter 1 (§§ 4001–4006) of subtitle A of title IV of Pub. L. 105–33.

REPORT ON INTEGRATION AND TRANSITION

Pub. L. 105–33, title IV, § 4014(c), Aug. 5, 1997, 111 Stat. 337, directed the Secretary of Health and Human Services to submit to Congress, no later than Jan. 1, 1999, a plan which provided for the integration of health plans offered by social health maintenance organizations and similar plans as an option under the Medicare+Choice program under this part, for a transition for such organizations operating under demonstration project authority, and for appropriate payment levels for plans offered by such organizations.

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, § 4018, Aug. 5, 1997, 111 Stat. 346, provided that:

''(a) DEMONSTRATION PROJECT.—

''(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the 'project') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as added by section 4001 of this Act), in an area.

''(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

''(A) the design of the project;

''(B) the selection criteria for the third-party contractor; and

''(C) the establishment of performance standards, as described in paragraph (3).

''(3) PERFORMANCE STANDARDS.—

''(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

''(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

''(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

''(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

''(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

''(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.''

§ 1395w–22. Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w–28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term ''benefits under the original medicare fee-for-service program option'' means, subject to subsection (m), those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits

under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1395w–27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).

(III) Skilled nursing care.

(IV) Clinical diagnostic laboratory test administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 and the administration of such test.

(V) Specified COVID–19 testing-related services (as described in section 1395*l*(cc)(1) of this title) for which payment would be payable under a specified outpatient payment provision described in section 1395*l*(cc)(2) of this title.

(VI) A COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title.

(VII) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv), other than subclauses (IV), (V), and (VI) of such clause, for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(vi) Prohibition of application of certain requirements for COVID–19 testing

In the case of a product or service described in subclause (IV) or (V), respectively, of clause (iv) that is administered or furnished during any portion of the emergency period described in such subclause beginning on or after March 18, 2020, an MA plan may not impose any prior authorization or other utilization management requirements with respect to the coverage of such a product or service under such plan.

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) Reference to related provisions

For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) and section 1395cc(a)(1)(O) of this title, and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w–24(e) of this title.

(C) Election of uniform coverage determination

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Subject to subparagraph (D), each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w–28(b)(2)(B) of this title. In applying the previous sentence, health benefits de-

scribed in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title.

(D) Expanding supplemental benefits to meet the needs of chronically ill enrollees

(i) In general

For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1395w–28(b)(6) of this title), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

(ii) Supplemental benefits described

(I) In general

Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

(II) Authority to waive uniformity requirements

The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

(iii) Chronically ill enrollee defined

In this subparagraph, the term ''chronically ill enrollee'' means an enrollee in an MA plan that the Secretary determines—

(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

(II) has a high risk of hospitalization or other adverse health outcomes; and

(III) requires intensive care coordination.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w–23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1395w–23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w–21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) Special benefit rules for regional plans

In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1395w–27a(b) of this title.

(7) Limitation on cost-sharing for dual eligibles and qualified medicare beneficiaries

In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) or a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title, the plan may not impose cost-sharing that exceeds the

amount of cost-sharing that would be permitted with respect to the individual under subchapter XIX if the individual were not enrolled in such plan.

(b) Antidiscrimination

(1) Beneficiaries

A Medicare Advantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.[1] The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

(2) Providers

A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) Disclosure requirements

(1) Detailed description of plan provisions

A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) Service area

The plan's service area.

(B) Benefits

Benefits offered under the plan, including information described in section 1395w–21(d)(3)(A) of this title and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) Access

The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

(D) Out-of-area coverage

Out-of-area coverage provided by the plan.

(E) Emergency coverage

Coverage of emergency services, including—

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) Supplemental benefits

Supplemental benefits available from the organization offering the plan, including—

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) Prior authorization rules

Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) Plan grievance and appeals procedures

All plan appeal or grievance rights and procedures.

(I) Quality improvement program

A description of the organization's quality improvement program under subsection (e).

(2) Disclosure upon request

Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1395w–21(d)(2)(A) of this title.

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(d) Access to services

(1) In general

A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered

[1] See References in Text note below.

under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) Guidelines respecting coordination of post-stabilization care

A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1395dd of this title.

(3) "Emergency services" defined

In this subsection—

(A) In general

The term ''emergency services'' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) Emergency medical condition based on prudent layperson

The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

(4) Assuring access to services in Medicare+Choice private fee-for-service plans

In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

(5) Requirement of certain nonemployer Medicare Advantage private fee-for-service plans to use contracts with providers

(A) In general

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1395w–27(i) of this title operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) Network area defined

For purposes of subparagraph (A), the term ''network area'' means, for a plan year, an area which the Secretary identifies (in the Secretary's announcement of the proposed payment rates for the previous plan year under section 1395w–23(b)(1)(B) of this title) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) Network-based plan defined

(i) In general

For purposes of subparagraph (B), the term ''network-based plan'' means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1395w–21(a)(2)(A)(i) of this title;

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1395mm of this title.

(ii) Exclusion of non-network regional PPOS

The term ''network-based plan'' shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) Requirement of all employer Medicare Advantage private fee-for-service plans to use contracts with providers

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1395w–27(i) of this title, the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(e) Quality improvement program

(1) In general

Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) Chronic care improvement programs

As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) Data

(A) Collection, analysis, and reporting

(i) In general

Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) Special requirements for specialized MA plans for special needs individuals

In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) Application to local preferred provider organizations and MA regional plans

Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) Definition of preferred provider organization plan

In this subparagraph, the term ''preferred provider organization plan'' means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) Limitations

(i) Types of data

The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) Changes in types of data

Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subpara-

graph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) Construction

Nothing in the[2] subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1395w–21(d)(4)(D) of this title.

(4) Treatment of accreditation

(A) In general

The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1395w–26 of this title to carry out the requirements in such clause.

(B) Requirements described

The provisions described in this subparagraph are the following:

(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(vii) The requirements described in section 1395w–104(j) of this title, to the extent such requirements apply under section 1395w–131(c) of this title.

(C) Timely action on applications

The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1395bb(a)(2) of this title, whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) Construction

Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1395w–27 of this title, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

[2] So in original. Probably should be ''this''.

(f) Grievance mechanism

Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests

In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response

In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) Appeals

An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(h) Confidentiality and accuracy of enrollee records

Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) Information on advance directives

Each Medicare+Choice organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(j) Rules regarding provider participation

(1) Procedures

Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) Consultation in medical policies

A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) Prohibiting interference with provider advice to enrollees

(A) In general

Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization

under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection

Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Construction

Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(D) "Health care professional" defined

For purposes of this paragraph, the term ''health care professional'' means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Limitations on physician incentive plans

(A) In general

No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) "Physician incentive plan" defined

In this paragraph, the term ''physician incentive plan'' means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) Limitation on provider indemnification

A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) Special rules for Medicare+Choice private fee-for-service plans

For purposes of applying this part (including subsection (k)(1)) and section 1395cc(a)(1)(O) of this title, a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity—

(i) has been informed of the individual's enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) Promotion of e-prescribing by MA plans

(A) In general

An MA–PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1395w–104(e) of this title.

(B) Considerations

Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) Structure

Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1395w–104(c)(2)(E)[1] of this title.

(k) Treatment of services furnished by certain providers

(1) In general

Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1395w–21(a)(2)(A) of this title or with an organization offering an MSA plan shall accept as payment in full for covered services under this subchapter that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this subchapter (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) Application to Medicare+Choice private fee-for-service plans

(A) Balance billing limits under Medicare+Choice private fee-for-service plans in case of contract providers

(i) In general

In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this subchapter that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) Procedures to enforce limits

The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1395w–4(g)(1)(A) of this title, in order to carry out the previous sentence.

(iii) Assuring enforcement

If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1395w–27(g) of this title.

(B) Enrollee liability for noncontract providers

For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see subsection (a)(2); or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1395cc(a)(1)(O) of this title.

(C) Information on beneficiary liability

(i) In general

Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) Advance notice before receipt of inpatient hospital services and certain other services

In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

***(l)* Return to home skilled nursing facilities for covered post-hospital extended care services**

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare+Choice

plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election

The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement

The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term ''home skilled nursing facility'' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission

The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community

A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge

The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term ''continuing care retirement community'' means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

(m) Provision of additional telehealth benefits

(1) MA plan option

For plan year 2020 and subsequent plan years, subject to the requirements of paragraph (3), an MA plan may provide additional telehealth benefits (as defined in paragraph (2)) to individuals enrolled under this part.

(2) Additional telehealth benefits defined

(A) In general

For purposes of this subsection and section 1395w–24 of this title:

(i) Definition

The term ''additional telehealth benefits'' means services—

(I) for which benefits are available under part B, including services for which payment is not made under section 1395m(m) of this title due to the conditions for payment under such section; and

(II) that are identified for such year as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1395x(r) of this title) or practitioner (described in section 1395u(b)(18)(C) of this title) providing the service is not at the same location as the plan enrollee.

(ii) Exclusion of capital and infrastructure costs and investments

The term ''additional telehealth benefits'' does not include capital and infrastructure costs and investments relating to such benefits.

(B) Public comment

Not later than November 30, 2018, the Secretary shall solicit comments on—

(i) what types of items and services (including those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication) should be considered to be additional telehealth benefits; and

(ii) the requirements for the provision or furnishing of such benefits (such as training and coordination requirements).

(3) Requirements for additional telehealth benefits

The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

(A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.

(B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.

(C) Such other areas as determined by the Secretary.

(4) Enrollee choice

If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2))—

(A) the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and

(B) an individual enrollee shall have discretion as to whether to receive such service through the in-person visit or as an additional telehealth benefit.

(5) Treatment under MA

For purposes of this subsection and section 1395w–24 of this title, if a plan provides additional telehealth benefits, such additional telehealth benefits shall be treated as if they were benefits under the original Medicare fee-for-service program option.

(6) Construction

Nothing in this subsection shall be construed as affecting the requirement under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1395m(m) of this title.

(n) Provision of information relating to the safe disposal of certain prescription drugs

(1) In general

In the case of an individual enrolled under an MA or MA–PD plan who is furnished an in-home health risk assessment on or after January 1, 2021, such plan shall ensure that such assessment includes information on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under paragraph (2). Such information shall include information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal.

(2) Criteria

The Secretary shall, through rulemaking, establish criteria the Secretary determines appropriate with respect to information provided to an individual to ensure that such information sufficiently educates such individual on the safe disposal of prescription drugs that are controlled substances.

(Aug. 14, 1935, ch. 531, title XVIII, §1852, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 286; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(B), title V, §§518, 520(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–384, 1501A–385; Pub. L. 106–554, §1(a)(6) [title V, §521(b), title VI, §§611(b), 615, 616, 621(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–543, 2763A–560, 2763A–561, 2763A–564; Pub. L. 108–173, title I, §102(b), title II, §§211(j), 221(d)(3), 222(a)(2), (3), (h), (*l*)(1), 233(a)(1), (2), (c), title VII, §722(a), (b), title IX, §§900(e)(1)(F), 940(b)(2)(A), 948(b)(2), Dec. 8, 2003, 117 Stat. 2153, 2180, 2193, 2195, 2196, 2204, 2206, 2209, 2347, 2348, 2371, 2417, 2426; Pub. L. 110–275, title I, §§125(b)(6), 162(a)(1)–(3)(A), 163(a), (b), 164(f)(1), 165(a), July 15, 2008, 122 Stat. 2519, 2569–2571, 2574, 2575; Pub. L. 111–148, title III, §3202(a)(1), Mar. 23, 2010, 124 Stat. 454; Pub. L. 114–255, div. C, title XVII, §17006(a)(2)(A), (c)(1), Dec. 13, 2016, 130 Stat. 1334, 1335; Pub. L. 115–123, div. E, title III, §§50322(a), 50323(a), Feb. 9, 2018, 132 Stat. 201, 202; Pub. L. 115–271, title VI, §6103(a), Oct. 24, 2018, 132 Stat. 4005; Pub. L. 116–127, div. F, §6003(a), Mar. 18, 2020, 134 Stat. 203; Pub. L. 116–136, div. A, title III, §3713(c), Mar. 27, 2020, 134 Stat. 423.)

Editorial Notes

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (b)(1), is section 2702 of act July 1, 1944, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (j)(3)(C), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, as amended, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 1395w–104(c)(2)(E) of this title, referred to in subsec. (j)(7)(C), was redesignated section 1395w–104(c)(2)(G) of this title by Pub. L. 111–148, title X, §10328(a)(1), Mar. 23, 2010, 124 Stat. 964.

AMENDMENTS

2020—Subsec. (a)(1)(B)(iv)(IV), (V). Pub. L. 116–127, §6003(a)(1)(B), added subcls. (IV) and (V). Former subcl. (IV) redesignated (VI).

Subsec. (a)(1)(B)(iv)(VI). Pub. L. 116–136, §3713(c)(1)(B), added subcl. (VI). Former subcl. (VI) redesignated (VII).

Pub. L. 116–127, §6003(a)(1)(A), redesignated subcl. (IV) as (VI).

Subsec. (a)(1)(B)(iv)(VII). Pub. L. 116–136, §3713(c)(1)(A), redesignated subcl. (VI) as (VII).

Subsec. (a)(1)(B)(v). Pub. L. 116–136, §3713(c)(2), substituted ''subclauses (IV), (V), and (VI)'' for ''subclauses (IV) and (V)''.

Pub. L. 116–127, §6003(a)(2), inserted '', other than subclauses (IV) and (V) of such clause,'' after ''clause (iv)''.

Subsec. (a)(1)(B)(vi). Pub. L. 116–127, §6003(a)(3), added cl. (vi).

2018—Subsec. (a)(1)(B)(i). Pub. L. 115–123, §50323(a)(1), inserted '', subject to subsection (m),'' after ''means''.

Subsec. (a)(3)(A). Pub. L. 115–123, §50322(a)(1), substituted ''Subject to subparagraph (D), each'' for ''Each''.

Subsec. (a)(3)(D). Pub. L. 115–123, §50322(a)(2), added subpar. (D).

Subsec. (m). Pub. L. 115–123, § 50323(a)(2), added subsec. (m).

Subsec. (n). Pub. L. 115–271 added subsec. (n).

2016—Subsec. (a)(1)(B)(i). Pub. L. 114–255, § 17006(c)(1), inserted ''or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title'' after ''hospice care''.

Subsec. (b)(1). Pub. L. 114–255, § 17006(a)(2)(A), struck out subpar. (A) designation and heading, substituted ''A Medicare Advantage organization'' for ''A Medicare+Choice organization'', and struck out subpar. (B). Prior to amendment, text of subpar. (B) read as follows: ''Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1395w–21(a)(3)(B) of this title.''

2010—Subsec. (a)(1)(B)(i). Pub. L. 111–148, § 3202(a)(1)(A), inserted '', subject to clause (iii),'' after ''and B or''.

Subsec. (a)(1)(B)(iii) to (v). Pub. L. 111–148, § 3202(a)(1)(B), added cls. (iii) to (v).

2008—Subsec. (a)(7). Pub. L. 110–275, § 165(a), added par. (7).

Subsec. (d)(4). Pub. L. 110–275, § 162(a)(1)(A), (2)(A), in introductory provisions, substituted ''Subject to paragraphs (5) and (6), the Secretary'' for ''The Secretary'' in second sentence.

Subsec. (d)(4)(B). Pub. L. 110–275, § 162(a)(3)(A), substituted ''a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)'' for ''a sufficient number and range of providers within such category to provide covered services under the terms of the plan''.

Subsec. (d)(5). Pub. L. 110–275, § 162(a)(1)(B), added par. (5).

Subsec. (d)(6). Pub. L. 110–275, § 162(a)(2)(B), added par. (6).

Subsec. (e)(1). Pub. L. 110–275, § 163(a), struck out ''(other than an MA private fee-for-service plan or an MSA plan)'' before period at end.

Subsec. (e)(3)(A)(i). Pub. L. 110–275, § 163(b)(1), inserted at end ''With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.''

Subsec. (e)(3)(A)(ii). Pub. L. 110–275, §§ 163(b)(2), 164(f)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: ''The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.''

Subsec. (e)(3)(A)(iii). Pub. L. 110–275, § 163(b)(3), inserted ''local'' after ''to'' and ''and MA regional plans'' after ''organizations'' in heading and ''and to MA regional plans'' after ''organization plans'' in text.

Subsec. (e)(4)(C). Pub. L. 110–275, § 125(b)(6), substituted ''section 1395bb(a)(2)'' for ''section 1395bb(b)(2)''.

2003—Subsec. (a)(1). Pub. L. 108–173, § 222(a)(2), substituted ''Requirement'' for ''In general'' in par. heading, designated existing provisions as subpar. (A), inserted heading, substituted ''chapter, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title).'' for ''chapter—'', added subpar. (B), and struck out former subpars. (A) and (B) which read as follows:

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals residing in the area served by the plan, and

''(B) additional benefits required under section 1395w–24(f)(1)(A) of this title.''

Pub. L. 108–173, § 221(d)(3)(A), inserted ''and except as provided in paragraph (6) for MA regional plans'' after ''MSA plans'' in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 108–173, § 948(b)(2), substituted ''determination'' for ''policy'' wherever appearing in heading and text.

Subsec. (a)(3)(C). Pub. L. 108–173, § 222(a)(3), which directed insertion of ''Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title.'' at the end of par. (3), was executed by making the insertion at the end of the final subpar. in par. (3), which was subpar. (C), to reflect the probable intent of Congress.

Subsec. (a)(5). Pub. L. 108–173, § 900(e)(1)(F), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration'' in concluding provisions.

Subsec. (a)(6). Pub. L. 108–173, § 221(d)(3)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108–173, § 222(*l*)(1), inserted at end ''The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.''

Subsec. (c)(1)(I). Pub. L. 108–173, § 722(b), amended heading and text of subpar. (I) generally. Prior to amendment, text read as follows: ''A description of the organization's quality assurance program under subsection (e) of this section, if required under such section.''

Pub. L. 108–173, § 233(a)(2)(A), inserted '', if required under such section'' before period at end.

Subsec. (d)(4). Pub. L. 108–173, § 211(j)(2), inserted before period at end of concluding provisions '', except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan''.

Subsec. (d)(4)(B). Pub. L. 108–173, § 211(j)(1), inserted ''(other than deemed contracts or agreements under subsection (j)(6))'' after ''the plan has contracts or agreements''.

Subsec. (e). Pub. L. 108–173, § 722(a)(1), substituted ''improvement'' for ''assurance'' in heading.

Subsec. (e)(1). Pub. L. 108–173, § 722(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans (other than MSA plans) of the organization.''

Pub. L. 108–173, § 233(a)(1), inserted ''(other than MSA plans)'' after ''plans''.

Subsec. (e)(2). Pub. L. 108–173, § 722(a)(2), amended par. (2) generally, substituting provisions relating to chronic care improvement programs for provisions relating to elements of the quality assurance program of an organization with respect to a Medicare+Choice plan.

Subsec. (e)(2)(A). Pub. L. 108–173, § 233(a)(2)(B), struck out '', a non-network MSA plan,'' after ''fee-for-service plan'' in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 108–173, § 233(a)(2)(C), struck out '', non-network MSA plans,'' after ''fee-for-service plans'' in heading and '', a non-network MSA plan,'' after ''fee-for-service plan'' in introductory provisions.

Subsec. (e)(3). Pub. L. 108–173, § 722(a)(2), amended par. (3) generally, substituting provisions relating to collection, analysis, and reporting of data for provisions relating to external review by an independent quality review and improvement organization.

Subsec. (e)(4)(B)(i). Pub. L. 108–173, §722(a)(3)(A), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: ''Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).''

Subsec. (e)(4)(B)(vii). Pub. L. 108–173, §722(a)(3)(B), added cl. (vii).

Subsec. (e)(5). Pub. L. 108–173, §722(a)(4), struck out par. (5), which related to report to be submitted to Congress not later than 2 years after Dec. 21, 2000, and biennially thereafter, regarding how quality assurance programs focus on racial and ethnic minorities.

Subsec. (g)(5). Pub. L. 108–173, §940(b)(2)(A), inserted at end ''The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.''

Subsec. (j)(4)(A). Pub. L. 108–173, §222(h)(1), inserted ''the organization provides assurances satisfactory to the Secretary that'' after ''unless'' in introductory provisions.

Subsec. (j)(4)(A)(ii). Pub. L. 108–173, §222(h)(2), substituted ''the organization'' for ''the organization—'', struck out subcl. (I) designation before ''provides'', substituted period for '', and'' at end of subcl. (I), and struck out subcl. (II), which read as follows: ''conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.''

Subsec. (j)(4)(A)(iii). Pub. L. 108–173, §222(h)(3), struck out cl. (iii) which read as follows: ''The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.''

Subsec. (j)(7). Pub. L. 108–173, §102(b), added par. (7).

Subsec. (k)(1). Pub. L. 108–173, §233(c), inserted ''or with an organization offering an MSA plan'' after ''section 1395w–21(a)(2)(A) of this title''.

2000—Subsec. (a)(2)(C). Pub. L. 106–554, §1(a)(6) [title VI, §615], added subpar. (C).

Subsec. (a)(5). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(5)], inserted concluding provisions.

Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(1), (2)], inserted ''and legislative changes in benefits'' after ''National coverage determinations'' in heading and inserted ''or legislative change in benefits required to be provided under this part'' after ''there is a national coverage determination'' in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(3)], inserted ''or legislative change in benefits'' after ''such determination''.

Subsec. (a)(5)(B). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(4)], inserted ''or legislative change'' after ''if such coverage determination''.

Subsec. (e)(2)(A), (B). Pub. L. 106–554, §1(a)(6) [title VI, §616(a)], inserted concluding provisions.

Subsec. (e)(5). Pub. L. 106–554, §1(a)(6) [title VI, §616(b)], added par. (5).

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title V, §521(b)], inserted at end ''The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.''

Subsec. (*l*). Pub. L. 106–554, §1(a)(6) [title VI, §621(a)], added subsec. (*l*).

1999—Subsec. (a)(3)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(i)], struck out comma after ''MSA plan'' and inserted comma after ''the coverage)''.

Subsec. (e)(2)(A). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(1)], substituted '', a non-network MSA plan, or a preferred provider organization plan'' for ''or a non-network MSA plan'' in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(2)], substituted '', non-network MSA plans, and preferred provider organization plans'' for ''and non-network MSA plans'' in heading and '', a non-network MSA plan, or a preferred provider organization plan'' for ''or a non-network MSA plan'' in introductory provisions.

Subsec. (e)(2)(D). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(3)], added subpar. (D).

Subsec. (e)(4). Pub. L. 106–113, §1000(a)(6) [title V, §518], amended heading and text of par. (4) generally. Prior to amendment, text read as follows: ''The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) of this section (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1395w–26 of this title to carry out the respective requirements.''

Subsec. (g)(1)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(I)], inserted ''or'' after ''in whole''.

Subsec. (g)(3)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(II)], inserted period at end.

Subsec. (h)(2). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(iii)], substituted a semicolon for a comma before ''and''.

Subsec. (k)(2)(C)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(iv)], substituted ''balance'' for ''balancing'' before ''billing under subparagraph (A) could'' in introductory provisions.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 3713(c) of Pub. L. 116–136 effective on Mar. 27, 2020, and applicable with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 262 of this title, see section 3713(d) of Pub. L. 116–136, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 17006(a)(2)(A) of Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(a)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

Amendment by section 17006(c)(1) of Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(c)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3202(a)(2), Mar. 23, 2010, 124 Stat. 454, provided that: ''The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2011.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(6) of Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110–275, title I, §162(a)(3)(B), July 15, 2008, 122 Stat. 2571, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to plan year 2010 and subsequent plan years.''

Pub. L. 110–275, title I, §163(c), July 15, 2008, 122 Stat. 2571, provided that: ''The amendments made by this section [amending this section] shall apply to plan years beginning on or after January 1, 2010.''

Pub. L. 110–275, title I, §164(f)(2), July 15, 2008, 122 Stat. 2575, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.].''

Pub. L. 110–275, title I, §165(b), July 15, 2008, 122 Stat. 2575, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2010.''

EFFECTIVE AND TERMINATION DATES OF 2003 AMENDMENT

Amendment by sections 221(d)(3) and 222(a)(2), (3), (h), (*l*)(1) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

Pub. L. 108–173, title II, §233(a)(3), Dec. 8, 2003, 117 Stat. 2209, provided that: ''The amendments made by this subsection [amending this section] shall apply on and after the date of the enactment of this Act [Dec. 8, 2003] but shall not apply to contract years beginning on or after January 1, 2006.''

Pub. L. 108–173, title VII, §722(c), Dec. 8, 2003, 117 Stat. 2348, provided that: ''The amendments made by this section [amending this section] shall apply with respect to contract years beginning on and after January 1, 2006.''

Amendment by section 948(b)(2) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554), see section 948(e) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title V, §521(b)] of Pub. L. 106–554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106–554, set out as a note under section 1320c–3 of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §611(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: ''The amendments made by this section [amending this section and section 1395w–23 of this title] are effective on the date of the enactment of this Act [Dec. 21, 2000] and shall apply to national coverage determinations and legislative changes in benefits occurring on or after such date.''

Pub. L. 106–554, §1(a)(6) [title VI, §621(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(B)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §520(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that: ''The amendments made by subsection (a) [amending this section] apply to contract years beginning on or after January 1, 2000.''

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–127, div. F, §6003(b), Mar. 18, 2020, 134 Stat. 204, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise.''

MEDPAC STUDY

Pub. L. 106–554, §1(a)(6) [title VI, §621(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) [amending this section] on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had—

''(A) on the scope of additional benefits provided under the Medicare+Choice program;

''(B) on the administrative and other costs incurred by Medicare+Choice organizations; and

''(C) on the contractual relationships between such organizations and skilled nursing facilities.

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

TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–355, provided that: ''The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section [amending sections 1395k and 1395x of this title] for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A).''

§ 1395w–23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w–27 of this title and subject to subsections (e), (g), (i), and (*l*) and section 1395w–28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to 1/12 of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) Demographic adjustment, including adjustment for health status

(i) In general

Subject to subparagraph (I), the Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) Application of coding adjustment

For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part[1] A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions

(I) In general

For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized

[1] So in original. Probably should be ''parts''.

MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title).

(II) Individuals described

An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii)[2] who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) Evaluation

For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) Publication of evaluation and revisions

The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

(D) Separate payment for Federal drug subsidies

In the case of an enrollee in an MA–PD plan, the MA organization offering such plan also receives—

(i) subsidies under section 1395w–115 of this title (other than under subsection (g)); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1395w–114(c)(1)(C) of this title.

(E) Payment of rebate for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year (as reduced by the amount of any credit provided under section 1395w–24(b)(1)(C)(iv)[2] of this title).

(F) Adjustment for intra-area variations

(i) Intra-regional variations

In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) Intra-service area variations

In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) Adjustment relating to risk adjustment

The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

(i) the sum of—

(I) the monthly payment made under subparagraph (A)(ii); and

(II) the MA monthly basic beneficiary premium under section 1395w–24(b)(2)(A) of this title; equals

(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before December 8, 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

[2] See References in Text note below.

(I) Improvements to risk adjustment for 2019 and subsequent years

(i) In general

In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

(I) Taking into account total number of diseases or conditions

The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

(II) Using at least 2 years of diagnostic data

The Secretary may use at least 2 years of diagnosis data.

(III) Providing separate adjustments for dual eligible individuals

With respect to individuals who are dually eligible for benefits under this subchapter and subchapter XIX, the Secretary shall make separate adjustments for each of the following:

(aa) Full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title).

(bb) Such individuals not described in item (aa).

(IV) Evaluation of mental health and substance use disorders

The Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.

(V) Evaluation of chronic kidney disease

The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model.

(VI) Evaluation of payment rates for end-stage renal disease

The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

(ii) Phased-in implementation

The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

(iii) Opportunity for review and public comment

The Secretary shall provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1395w–22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

The Secretary shall first provide for implementation of a risk adjustment meth-

odology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

Subject to section 1395w–28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(4) Payment rule for federally qualified health center services

If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1395w–27(e)(3) of this title)—

(A) the Secretary shall pay the amount determined under section 1395*l*(a)(3)(B) of this title directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) Annual announcement of payment rates

(1) Annual announcements

(A) For 2005

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA capitation rates

The annual MA capitation rate for each MA payment area for 2005.

(ii) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

(B) For 2006 and subsequent years

For a year after 2005—

(i) Initial announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA capitation rates; MA local area benchmark

The annual MA capitation rate for each MA payment area for the year.

(II) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

(ii) Regional benchmark announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1395w–24 of this title, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) Benchmark announcement for CCA local areas

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1395w–29(b)(1)(A)[2] of this title), the CCA non-drug monthly benchmark amount under section 1395w–29(e)(1)[2] of this title for that area for the year involved.

(2) Advance notice of methodological changes

At least 45 days (or, in 2017 and each subsequent year, at least 60 days) before making the

announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity (in 2017 and each subsequent year, of no less than 30 days) to comment on such proposed changes.

(3) Explanation of assumptions

In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in such announcement.

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 426–1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) Blended capitation rate

For a year before 2005, the sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) Minimum amount

12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 percent of fee-for-service costs

(i) In general

For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections,[3] 1395w–4(*o*), and[3] 1395ww(n) and 1395ww(h) of this title.

(ii) Periodic rebasing

The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) Inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries

In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) Area-specific and national percentages

For purposes of paragraph (1)(A)—

(A) for 1998, the ''area-specific percentage'' is 90 percent and the ''national percentage'' is 10 percent,

(B) for 1999, the ''area-specific percentage'' is 82 percent and the ''national percentage'' is 18 percent,

(C) for 2000, the ''area-specific percentage'' is 74 percent and the ''national percentage'' is 26 percent,

(D) for 2001, the ''area-specific percentage'' is 66 percent and the ''national percentage'' is 34 percent,

(E) for 2002, the ''area-specific percentage'' is 58 percent and the ''national percentage'' is 42 percent, and

(F) for a year after 2002, the ''area-specific percentage'' is 50 percent and the ''national percentage'' is 50 percent.

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under State hospital reimbursement system

To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

[3] So in original.

(E) Inclusion of costs of DOD and VA military facility services to Medicare-eligible beneficiaries

In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this subchapter that are used in applying (or updating) national payment rates for specific areas and localities.

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the ''national standardized annual Medicare+Choice capitation rate'' for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) Special rules for 1998

In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w–4(e) of this title used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) Payment adjustment budget neutrality factor

For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) "National per capita Medicare+Choice growth percentage" defined

(A) In general

In this part, the ''national per capita Medicare+Choice growth percentage'' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this subchapter for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (*o*) of section 1395w–4 of this title and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title, reduced by the number of percentage points specified in

subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is—

(i) for 1998, 0.8 percentage points,

(ii) for 1999, 0.5 percentage points,

(iii) for 2000, 0.5 percentage points,

(iv) for 2001, 0.5 percentage points,

(v) for 2002, 0.3 percentage points, and

(vi) for a year after 2002, 0 percentage points.

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) Adjustment for national coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA payment area; MA local area; MA region defined

(1) MA payment area

In this part, except as provided in this subsection, the term ''MA payment area'' means—

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1395w–27a(a)(2) of this title).

(2) MA local area

The term ''MA local area'' means a county or equivalent area specified by the Secretary.

(3) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) Geographic adjustment

(A) In general

Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) Budget neutrality adjustment

In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) Areas

In subparagraph (C), the terms ''metropolitan statistical area'', ''consolidated metropolitan statistical area'', and ''primary metropolitan statistical area'' mean any area designated as such by the Secretary of Commerce.

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w–24(b)(2)(C) of this title) for an MSA plan

for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) Lump-sum deposit of medical savings account contribution

In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) Payments from Trust Funds

The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (*l*) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this subchapter. Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v)[2] of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title) as of the effective date of the individual's—

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1395w–21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) Special rule for hospice care

(1) Information

A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this subchapter is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w–24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) Period of application

Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) Offered defined

In this subsection, the term ''offered'' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) Computation of benchmark amounts

For purposes of this part, subject to subsection (*o*), the term ''MA area-specific non-drug monthly benchmark amount'' means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1395w–29(d)(2)(A)[2] of this title, an amount equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1395w–24(a)(6)(A)(iii) of this title), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1395w–27a(f) of this title for the region for the year.

(k) Determination of applicable amount for purposes of calculating the benchmark amounts

(1) Applicable amount defined

For purposes of subsection (j), subject to paragraphs (2), (4), and (5), the term ''applicable amount'' means for an area—

(A) for 2007—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2), (4), and (5)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) Phase-out of budget neutrality factor

(A) In general

Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

(i) the percent determined under subparagraph (B) for the year; and

(ii) the applicable phase-out factor for the year under subparagraph (C).

(B) Percent determined

(i) In general

For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) Numerator based on difference between demographic rate and risk rate

(I) In general

The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) Demographic rate

The demographic rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) Risk rate

The risk rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) Denominator based on risk rate

The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) Requirements

In estimating the amounts under the previous clauses, the Secretary shall—

(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) Authority

In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) Applicable phase-out factor

For purposes of subparagraph (A)(ii), the term ''applicable phase-out factor'' means—

(i) for 2007, 0.55;

(ii) for 2008, 0.40;

(iii) for 2009, 0.25; and

(iv) for 2010, 0.05.

(D) Termination of application

Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) No revision in percent

(A) In general

The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) Rule of construction

Nothing in this subsection shall be construed to limit the authority of the Sec-

retary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) Phase-out of the indirect costs of medical education from capitation rates

(A) In general

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1395ww(d)(5)(B) of this title in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) Percentages defined

For purposes of this paragraph:

(i) Phase-in percentage

The term ''phase-in percentage'' means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) Maximum cumulative adjustment percentage

The term ''maximum cumulative adjustment percentage'' means, for—

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) Standardized IME cost percentage

The term ''standardized IME cost percentage'' means, for an area for a year, the per capita costs for payments under section 1395ww(d)(5)(B) of this title (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) Fee-for-service amount

The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.

(5) Exclusion of costs for kidney acquisitions from capitation rates

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this subchapter (including expenses covered under section 1395rr(d) of this title) in the area for the year.

***(l)* Application of eligible professional incentives for certain MA organizations for adoption and meaningful use of certified EHR technology**

(1) In general

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395w–4(*o*) and 1395w–4(a)(7) of this title shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible professional described

With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1395w–4(*o*) of this title) who—

(A)(i) is employed by the organization; or

(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this subchapter to enrollees of the organization; and

(B) furnishes, on average, at least 20 hours per week of patient care services.

(3) Eligible professional incentive payments

(A) In general

In applying section 1395w–4(*o*) of this title under paragraph (1), instead of the additional payment amount under section 1395w–4(*o*)(1)(A) of this title and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

(B) Avoiding duplication of payments

(i) In general

In the case of an eligible professional described in paragraph (2)—

(I) that is eligible for the maximum incentive payment under section 1395w–4(*o*)(1)(A) of this title for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1395w–4(*o*)(1)(A) of this title.

(ii) Methods

In the case of an eligible professional described in paragraph (2) who is eligible for

an incentive payment under section 1395w–4(*o*)(1)(A) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1395w–4(*o*)(1)(A) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(C) Fixed schedule for application of limitation on incentive payments for all eligible professionals

In applying section 1395w–4(*o*)(1)(B)(ii) of this title under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) Payment adjustment

(A) In general

In applying section 1395w–4(a)(7) of this title under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) Specified percent

The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of percentage points by which the applicable percent (under section 1395w–4(a)(7)(A)(ii) of this title) for the year is less than 100 percent; and

(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) Medicare physician expenditure proportion

The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) Application of payment adjustment

In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) Qualifying MA organization defined

In this subsection and subsection (m), the term ''qualifying MA organization'' means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 300gg–91(b)(3) of this title).

(6) Meaningful EHR user attestation

For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1395w–24(a)(1)(A)(iv)[4] of this title, identifying—

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1395w–4(*o*)(2) of this title) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1),[5] with respect to such organization, is a meaningful EHR user (as defined in section 1395ww(n)(3) of this title) for an applicable period specified by the Secretary.

(7) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

(B) the eligible professionals of such organization for which such incentive payment is based.

(8) Limitation on review

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

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

(B) the methodology and standards for determining eligible professionals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395w–4(*o*)(2) of this title, including specification of the means of demonstrating meaningful EHR use under section 1395w–4(*o*)(3)(C)[6] of this title and selection of measures under section 1395w–4(*o*)(3)(B)[7] of this title.

---

[4] So in original. Section 1395w–24(a)(1)(A) of this title does not contain a cl. (iv).

[5] So in original. Probably should be ''(m)(2),''.

[6] So in original. Probably should be ''1395w–4(*o*)(2)(C)''.

[7] So in original. Probably should be ''1395w–4(*o*)(2)(B)''.

(m) Application of eligible hospital incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) Application

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395ww(n) and 1395ww(b)(3)(B)(ix) of this title shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (*l*)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible hospital described

With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1395ww(n)(6)(B) of this title) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) Eligible hospital incentive payments

(A) In general

In applying section 1395ww(n)(2) of this title under paragraph (1), instead of the additional payment amount under section 1395ww(n)(2) of this title, there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1395ww(n)(2)(C) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1395ww(n)(2)(D) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) Avoiding duplication of payments

(i) In general

In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1395ww(n) of this title and not under this subsection.

(ii) Methods

In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1395ww(n) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1395ww(n) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(4) Payment adjustment

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in subsection (*l*)(5)), if, according to the attestation of the organization submitted under subsection (*l*)(6) for an applicable period, one or more eligible hospitals (as defined in section 1395ww(n)(6)(B) of this title) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1395ww(n)(3) of this title) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of the percentage point reduction effected under section 1395ww(b)(3)(B)(ix)(I) of this title for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from

such hospitals, that are not meaningful EHR users for such period.

(5) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) Limitations on review

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

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title, including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

(n) Determination of blended benchmark amount

(1) In general

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term ''blended benchmark amount'' means for an area—

(A) for 2012 the sum of—

(i) ½ of the applicable amount for the area and year; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) Specified amount

(A) In general

The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4) and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) Applicable percentage

Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) Periodic ranking

For purposes of this paragraph in the case of an area located—

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-year transition for changes in applicable percentage

If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) Base payment amount

Subject to subparagraphs (F) and (G), the base payment amount specified in this subparagraph—

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that—

(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) Application of indirect medical education phase-out

The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(G) Application of kidney acquisitions adjustment

The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) Alternative phase-ins

(A) 4-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $30 but less than $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I) ¾ of the applicable amount for the area and year; and

(II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I) ¼ of the applicable amount for the area and year; and

(II) ¾ of the amount specified in paragraph (2)(A) for the area and year; and

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I) ⅚ of the applicable amount for the area and year; and

(II) ⅙ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I) ⅔ of the applicable amount for the area and year; and

(II) ⅓ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of—

(I) ⅓ of the applicable amount for the area and year; and

(II) ⅔ of the amount specified in paragraph (2)(A) for the area and year; and

(v) for 2016 the sum of—

(I) ⅙ of the applicable amount for the area and year; and

(II) ⅚ of the amount specified in paragraph (2)(A) for the area and year; and

(vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) Projected 2010 benchmark amount

The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

(i) ½ of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—

(I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to ''the previous year'' were deemed a reference to 2010; and

(II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (*o*) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) Cap on benchmark amount

In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (*o*)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) Non-application to PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

***(o)* Applicable percentage quality increases**

(1) In general

Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

(A) for 2012, by 1.5 percentage points;

(B) for 2013, by 3.0 percentage points; and

(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) Increase for qualifying plans in qualifying counties

The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term ''qualifying plan'' means, for a year and subject to paragraph (4), a plan

that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) Application of increases to low enrollment plans

(I) 2012

For 2012, the term ''qualifying plan'' includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 and subsequent years

For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) Application of increases to new plans

(I) In general

A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased—

(aa) for 2012, by 1.5 percentage points;

(bb) for 2013, by 2.5 percentage points; and

(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) New MA plan defined

The term ''new MA plan'' means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) Qualifying county

The term ''qualifying county'' means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) Quality determinations for application of increase

(A) Quality determination

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w–22(e) of this title).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

For purposes of applying paragraph (1) and section 1395w–24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w–21(c)(4) of this title—

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization

(i) In general

If—

(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect to the offering of Medicare Advantage plans; and

(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract[8] (in this subparagraph referred to as a ''closed contract'') with the plans offered under a separate contract (in this subparagraph referred to as the ''continuing contract'');

with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1395w–24 of this title to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary.

(ii) Application

An adjustment under clause (i) shall apply for any year for which the quality rating of the continuing contract is based primarily on a measurement period that is prior to the first year in which a closed contract is no longer offered.

(5) Exception for PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

[8] So in original. Probably should be ''contracts''.

(6) Quality measurement at the plan level for SNPs

(A) In general

Subject to subparagraph (B), the Secretary may require reporting of data under section 1395w–22(e) of this title for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

(B) Considerations

Prior to applying quality measurement at the plan level under this paragraph, the Secretary shall—

(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

(ii) take into consideration the impact of such application on plans that serve a disproportionate number of individuals dually eligible for benefits under this subchapter and under subchapter XIX;

(iii) if quality measures are reported at the plan level, ensure that MA plans are not required to provide duplicative information; and

(iv) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

(C) Application

If the Secretary applies quality measurement at the plan level under this paragraph—

(i) such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; and

(ii) the Secretary shall consider applying administrative actions, such as remedies described in section 1395w–27(g)(2) of this title, at the plan level.

(7) Determination of feasibility of quality measurement at the plan level for all MA plans

(A) Determination of feasibility

The Secretary shall determine the feasibility of requiring reporting of data under section 1395w–22(e) of this title for, and applying under this subsection, quality measures at the plan level for all MA plans under this part.

(B) Consideration of change

After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph[3]

(Aug. 14, 1935, ch. 531, title XVIII, § 1853, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 299; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title V, §§ 511(a), 512, 514(a), 517], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, 1501A–382 to 1501A–384; Pub. L. 106–554, § 1(a)(6) [title VI, §§ 601(a), 602(a), 603, 605(a), 606(a)(2)(A), 607, 608(a), 611(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554 to 2763A–559; Pub. L. 107–188, title V, § 532(d)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, § 101(e)(3)(D), title II, §§ 211(a)–(e)(1), 221(d)(1), (4), 222(d)–(f), (i), 237(b)(1), (2)(B), 241(b)(1), title VII, § 736(d)(1), title IX, § 900(e)(1)(G), Dec. 8, 2003, 117 Stat. 2151, 2176–2178, 2192, 2193, 2200–2202, 2204, 2212, 2213, 2220, 2357, 2371; Pub. L. 109–171, title V, § 5301, Feb. 8, 2006, 120 Stat. 48; Pub. L. 110–275, title I, § 161(a), (b), July 15, 2008, 122 Stat. 2568, 2569; Pub. L. 111–5, div. B, title IV, §§ 4101(c), (e), 4102(c), (d)(3), Feb. 17, 2009, 123 Stat. 473, 476, 484, 486; Pub. L. 111–148, title III, §§ 3201(a)(1), (2)(A), (b), (e)(1), (2)(A)(ii)–(iv), (f)(1), (g), (h), (i)(2), 3202(b)(2), 3203, 3205(b), (f), title X, § 10318, Mar. 23, 2010, 124 Stat. 442, 444–447, 450, 452, 454–458, 948; Pub. L. 111–152, title I, § 1102(a)–(c)(3), (e), Mar. 30, 2010, 124 Stat. 1040, 1043, 1046; Pub. L. 112–240, title VI, § 639, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 114–10, title II, § 209(d), Apr. 16, 2015, 129 Stat. 150; Pub. L. 114–106, § 2, Dec. 18, 2015, 129 Stat. 2222; Pub. L. 114–113, div. O, title VI, § 602(b)(2), Dec. 18, 2015, 129 Stat. 3024; Pub. L. 114–255, div. C, title XVII, § 17006(b), (f)(1), Dec. 13, 2016, 130 Stat. 1334, 1336; Pub. L. 115–123, div. E, title III, § 50311(d), title XII, § 53112, Feb. 9, 2018, 132 Stat. 198, 305.)

Editorial Notes

REFERENCES IN TEXT

Subsection (b)(6)(B)(iii), referred to in subsec. (a)(1)(C)(iii)(II), probably means section 1395w–28(b)(6)(B)(iii) of this title. This section does not contain a subsec. (b)(6)(B)(iii).

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (a)(1)(E), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, § 3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, § 1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (a)(1)(H), is section 2355 of Pub. L. 98–369, div. B, title III, July 18, 1984, 98 Stat. 1103, as amended by section 13567(b) of Pub. L. 103–66, title XIII, Aug. 10, 1993, 107 Stat. 608, which is not classified to the Code.

Section 1395w–29 of this title, referred to in subsecs. (b)(1)(B)(iii) and (j)(1)(A), was repealed by Pub. L. 111–152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (e)(2)(A), is classified generally to Title 26, Internal Revenue Code.

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (g), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, § 15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2018—Subsec. (*o*)(4)(D). Pub. L. 115–123, § 53112, added subpar. (D).

Subsec. (*o*)(6), (7). Pub. L. 115–123, § 50311(d), added pars. (6) and (7).

2016—Subsec. (a)(1)(C)(i). Pub. L. 114–255, § 17006(f)(1)(A), which directed substitution of ''Subject to subparagraph (I), the Secretary'' for ''The Sec-

retary'', was executed by making the substitution in the first sentence to reflect the probable intent of Congress.

Subsec. (a)(1)(I). Pub. L. 114–255, §17006(f)(1)(B), added subpar. (I).

Subsec. (k)(1). Pub. L. 114–255, §17006(b)(1)(A)(i), substituted ''paragraphs (2), (4), and (5)'' for ''paragraphs (2) and (4)'' in introductory provisions.

Subsec. (k)(1)(B)(i). Pub. L. 114–255, §17006(b)(1)(A)(ii), substituted ''paragraphs (2), (4), and (5)'' for ''paragraphs (2) and (4)''.

Subsec. (k)(5). Pub. L. 114–255, §17006(b)(1)(B), added par. (5).

Subsec. (n)(2)(A)(i). Pub. L. 114–255, §17006(b)(2)(A), inserted before semicolon at end ''and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)''.

Subsec. (n)(2)(E). Pub. L. 114–255, §17006(b)(2)(B), substituted ''subparagraphs (F) and (G)'' for ''subparagraph (F)'' in introductory provisions.

Subsec. (n)(2)(G). Pub. L. 114–255, §17006(b)(2)(C), added subpar. (G).

2015—Subsec. (b)(2). Pub. L. 114–106 inserted ''(or, in 2017 and each subsequent year, at least 60 days)'' after ''45 days'' and ''(in 2017 and each subsequent year, of no less than 30 days)'' after ''opportunity''.

Subsec. (m)(2), (4)(A). Pub. L. 114–113 substituted ''1395ww(n)(6)(B)'' for ''1395ww(n)(6)(A)''.

Subsec. (*o*)(4)(C). Pub. L. 114–10 added subpar. (C).

2013—Subsec. (a)(1)(C)(ii)(III). Pub. L. 112–240 substituted ''1.5 percentage points'' for ''1.3 percentage points'' and ''5.9 percent'' for ''5.7 percent''.

2010—Subsec. (a)(1)(B)(i), (ii). Pub. L. 111–148, §3201(f)(1)(B), which directed amendment of subpar. (B) by inserting ''and any performance bonus under subsection (n)'' before period at end of cl. (i) and substituting ''(G), plus the amount (if any) of any performance bonus under subsection (n)'' for ''(G)'' in cl. (ii), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(1)(B)(iv). Pub. L. 111–148, §3205(b), added cl. (iv).

Subsec. (a)(1)(C)(ii). Pub. L. 111–152, §1102(e)(2), substituted ''and each subsequent year'' for ''through 2010'' in introductory provisions.

Pub. L. 111–152, §1102(e)(1), which directed the substitution of ''of coding adjustment'' for ''during phaseout of budget neutrality factor'' in heading, was executed by making the substitution for ''during phase-out of budget neutrality factor'' to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(ii)(II). Pub. L. 111–152, §1102(e)(3)(A)–(C), inserted ''annually'' before ''conduct an analysis'' and ''on a timely basis'' after ''are incorporated'', substituted ''for 2008 and subsequent years'' for ''only for 2008, 2009, and 2010'', and inserted ''and updated as appropriate'' after ''as available''.

Subsec. (a)(1)(C)(ii)(III), (IV). Pub. L. 111–152, §1102(e)(3)(D), which directed amendment ''in subclause (II)'' of subsec. (a)(1)(C)(ii) by adding subcls. (III) and (IV) at the end, was executed by adding subcls. (III) and (IV) after subcl. (II), to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(iii). Pub. L. 111–148, §3205(f), added cl. (iii).

Pub. L. 111–148, §3203, which directed amendment of subpar. (C) by adding cl. (iii) relating to application of coding intensity adjustment for 2011 and subsequent years, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

''(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

''(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.''

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(B)(i). Pub. L. 111–148, §3201(e)(2)(A)(ii), which directed amendment of cl. (i) by substituting ''MA local area (as defined in subsection (d)(2))'' for ''MA payment area'' in introductory provisions and ''MA local area (as so defined)'' for ''MA payment area'' in subcl. (I), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4). Pub. L. 111–148, §3201(e)(2)(A)(iii), which directed substitution of ''MA local area (as so defined)'' for ''Medicare Advantage payment area'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(1). Pub. L. 111–148, §3201(e)(2)(A)(iv), which directed amendment of par. (1) by striking ''a Medicare Advantage payment area that is'' in introductory provisions and substituting ''MA local area (as defined in subsection (d)(2))'' for ''MA payment area'' in subpar. (D)(i), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(6). Pub. L. 111–148, §3201(b), which directed amendment of par. (6) by substituting ''for 2003 through 2010'' for ''for a year after 2002'' in cl. (vi) and adding cl. (vii), which read ''for 2011, 3 percentage points; and'', and cl. (viii), which read ''for a year after 2011, 0 percentage points.'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d). Pub. L. 111–148, §3201(e)(1)(A), which directed substitution of ''MA region; MA local plan service area'' for ''MA region'' in heading, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(1)(A). Pub. L. 111–148, §3201(e)(1)(B), which directed substitution of ''with respect to an MA local plan—

''(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

''(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and''

for ''with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(5). Pub. L. 111–148, §3201(e)(1)(C), which directed the addition of par. (5), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows: ''For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

''(A) URBAN AREAS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

''(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

''(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

''(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

''(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL

PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of March 23, 2010)—

''(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

''(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.''

See Effective Date of 2010 Amendment note below.

Subsec. (d)(6). Pub. L. 111–148, § 3201(i)(2), which directed the addition of par. (6), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows: ''For years beginning with 2012, in the case of a PACE program under section 1395eee of this title, the MA payment area shall be the MA local area (as defined in paragraph (2)).'' See Effective Date of 2010 Amendment note below.

Subsec. (j). Pub. L. 111–152, § 1102(c)(1), inserted ''subject to subsection (*o*),'' after ''For purposes of this part,'' in introductory provisions.

Pub. L. 111–148, § 3201(a)(1)(A)–(C)(i), which directed the designation of existing provisions as par. (1), the insertion of par. (1) heading, the redesignation of former pars. (1) and (2) as subpars. (A) and (B), respectively, and former subpars. (A) and (B) of former par. (1) as cls. (i) and (ii) of subpar. (A), respectively, and the realignment of margins, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (j)(1)(A). Pub. L. 111–152, § 1102(b)(1), substituted ''for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year)'' for ''(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year''.

Pub. L. 111–148, § 3201(a)(1)(C)(ii), (iii), which, in cl. (i), directed substitution of ''section 1395w–29(d)(2)(A) of this title, an amount equal to—'' for ''section 1395w–29(d)(2)(A) of this title, an amount equal to'', subcls. (I) to (VI) for ''1/12 of the annual MA capitation rate under subsection (c)(1) (or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or'', and, in cl. (ii), directed substitution of ''clause (i)'' for ''subparagraph (A)'', was repealed by Pub. L. 111–152, § 1102(a). As enacted, subcls. (I) to (VI) read as follows:

''(I) for years before 2007, 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

''(III) for 2012, the sum of—

''(aa) 2/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

''(IV) for 2013, the sum of—

''(aa) 1/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

''(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

''(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or''.

See Effective Date of 2010 Amendment note below.

Subsec. (j)(2), (3). Pub. L. 111–148, § 3201(a)(1)(D), which directed addition of pars. (2) and (3), was repealed by Pub. L. 111–152, § 1102(a). As enacted, pars. (2) and (3) read as follows:

''(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1395w–24(b)(2)(E) of this title) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1395w–27a(f)(4) of this title, except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1395w–23(j)(2) of this title' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

''(B) WEIGHTING RULES.—

''(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

''(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

''(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.''

See Effective Date of 2010 Amendment note below.

Subsec. (k)(2). Pub. L. 111–148, § 3201(a)(1)(E), (2)(A), which directed amendment of par. (2) by substituting ''and subsequent years'' for ''through 2010'' in subpar. (A) and ''(j)(1)(A)(i)'' for ''(j)(1)(A)'' in subpar. (B)(ii)(III), and by adding, in subpar. (C), cl. (v), which read ''for 2011 and subsequent years, 0.00.'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (n). Pub. L. 111–152, § 1102(b)(2), added subsec. (n).

Pub. L. 111–148, § 3201(f)(1)(A), which directed addition of subsec. (n) relating to performance bonuses, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

''(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

''(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

''(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

''(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

''(i) Care management programs that—

''(I) target individuals with 1 or more chronic conditions;

''(II) identify gaps in care; and

''(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

''(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

''(I) help manage chronic conditions;

''(II) reduce declines in health status; and

''(III) foster patient and provider collaboration.

''(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

''(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

''(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

''(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

''(vii) Medication therapy management programs that are more extensive than is required under section 1395w–104(c) of this title (as determined by the Secretary).

''(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

''(ix) Such other care management and coordination programs as the Secretary determines appropriate.

''(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

''(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

''(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

''(2) QUALITY PERFORMANCE BONUSES.—

''(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

''(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating[)] on such system, 4 percent of such national monthly per capita cost for the year.

''(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

''(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

''(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

''(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

''(D) DATA USED IN DETERMINING SCORE.—

''(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

''(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

''(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

''(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1395w–24(a)(1)(A) of this title for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1395w–21(e) of this title, and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

''(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

''(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary

rebates described in section 1395w–24(b)(1)(C) of this title.

''(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

See Effective Date of 2010 Amendment note below.

Subsec. (n)(2)(B). Pub. L. 111–152, § 1102(c)(2), which directed insertion of '', subject to subsection (*o*)'' after ''as follows'' could not be executed because ''as follows'' did not appear in text.

Subsec. (n)(6). Pub. L. 111–148, § 3202(b)(2), which directed that subsec. (n), as added by Pub. L. 111–148, § 3201(f), be amended by adding a par. (6), was not executed to reflect the probable intent of Congress and the subsequent repeal of § 3201(f) by Pub. L. 111–152, § 1102(a). See Amendment note above.

Subsec. (*o*). Pub. L. 111–152, § 1102(c)(3), added subsec. (*o*).

Pub. L. 111–148, § 3201(g), which directed addition of subsec. (*o*) relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(*o*), 1395ww(n), and 1395ww(h) of this title.

''(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

''(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1395w–24(b)(1)(C) of this title. In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

''(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

''(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

''(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

''(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

''(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

''(i) for 2012 and 2013, the sum of—

''(I) the bid amount under section 1395w–24(a) of this title for the MA local plan; and

''(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

''(ii) for 2014 and subsequent years, the sum of—

''(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

''(II) the applicable amount (as so defined) for the MA local plan for the year.

''(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1395w–24(a) of this title for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

''(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

''(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1395w–24(c) of this title shall not apply with respect to the MA local plan.

''(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1395w–24(b)(1)(C) of this title, in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

''(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w–24(b)(1)(C) of this title.

''(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of March 23, 2010) in an MA local plan in an area that is identified by the Secretary under paragraph (1).''

See Effective Date of 2010 Amendment note below.

Subsec. (p). Pub. L. 111–148, § 3201(h), which directed addition of subsec. (p) relating to transitional extra benefits, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

''(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

''(A) enrolls in an MA local plan in an applicable area; and

''(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1395w–24(b)(1)(C) of this title as a result of competitive bidding under this part (as determined by the Secretary).

''(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

''(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

''(B) A county where—

''(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

''(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in

an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

''(iii) average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(*o*), 1395ww(n), and 1395ww(h) of this title.

''(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

''(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1395w–24(a) of this title for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

''(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits under this subsection.''

See Effective Date of 2010 Amendment note below.

Subsec. (p)(3)(A). Pub. L. 111–148, §10318, which directed that subsec. (p)(3)(A), as added by Pub. L. 111–148, §3201(h), be amended by inserting ''in 2009'' before the period at the end, was not executed to reflect the probable intent of Congress and the subsequent repeal of §3201(h) by Pub. L. 111–152, §1102(a). See Amendment note above.

2009—Subsec. (a)(1)(A). Pub. L. 111–5, §4101(e)(1), substituted ''(i), and (*l*)'' for ''and (i)''.

Subsec. (c)(1)(D)(i). Pub. L. 111–5, §4102(d)(3)(A)(i), substituted '', 1395w–4(*o*), and 1395ww(n)'' for ''1395w–4(*o*)''.

Pub. L. 111–5, §4101(e)(2)(A), substituted ''sections 1395w–4(*o*) and 1395ww(h) of this title'' for ''section 1395ww(h) of this title''.

Subsec. (c)(6)(A). Pub. L. 111–5, §4102(d)(3)(A)(ii), inserted ''and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title'' after ''1395w–4 of this title''.

Pub. L. 111–5, §4101(e)(2)(B), inserted ''excluding expenditures attributable to subsections (a)(7) and (*o*) of section 1395w–4 of this title,'' after ''under part B,''.

Subsec. (f). Pub. L. 111–5, §4102(d)(3)(B), inserted ''and subsection (m)'' after ''under subsection (*l*)''.

Pub. L. 111–5, §4101(e)(3), inserted ''and for payments under subsection (*l*)'' after ''with the organization''.

Subsec. (*l*). Pub. L. 111–5, §4101(c), added subsec. (*l*).

Subsec. (m). Pub. L. 111–5, §4102(c), added subsec. (m).

2008—Subsec. (k)(1). Pub. L. 110–275, §161(a)(1), (b), substituted ''paragraphs (2) and (4)'' for ''paragraph (2)'' in introductory provisions and cl. (i) of subpar. (B).

Subsec. (k)(4). Pub. L. 110–275, §161(a)(2), added par. (4).

2006—Subsec. (a)(1)(C). Pub. L. 109–171, §5301(b), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (j)(1)(A). Pub. L. 109–171, §5301(a)(1)(A), inserted ''(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1))'' after ''subsection (c)(1)'' and ''(for years before 2007)'' after ''adjusted as appropriate''.

Subsec. (j)(1)(B). Pub. L. 109–171, §5301(a)(1)(B), inserted ''(for years before 2007)'' after ''adjusted as appropriate''.

Subsec. (k). Pub. L. 109–171, §5301(a)(2), added subsec. (k).

2003—Subsec. (a)(1)(A). Pub. L. 108–173, §222(e)(1)(B), substituted ''amount determined as follows:'' and cls. (i) and (ii) for ''amount'' and provisions describing amount equal to 1/12 of the annual Medicare+Choice capitation rate, reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and adjusted for certain factors.

Subsec. (a)(1)(B) to (G). Pub. L. 108–173, §222(e)(1)(B), added subpars. (B) to (G). Former subpar. (B) redesignated (H).

Subsec. (a)(1)(H). Pub. L. 108–173, §222(i), substituted as second sentence provisions relating to actuarial equivalence of rates of payment to rates that would have been paid with respect to other enrollees in the MA payment area under this section as in effect before Dec. 8, 2003, for provisions relating to actuarial equivalence of rates of payment to rates paid to other enrollees in the Medicare+Choice payment area and inserted sentence at end authorizing application of the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

Pub. L. 108–173, §222(e)(1)(A), redesignated subpar. (B) as (H).

Subsec. (a)(3)(C)(ii). Pub. L. 108–173, §736(d)(1)(A), substituted ''clause (iv)'' for ''clause (iii)'' in introductory provisions.

Subsec. (a)(3)(C)(iii), (iv). Pub. L. 108–173, §736(d)(1)(B), redesignated cl. (iii), relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001, as (iv).

Subsec. (a)(4). Pub. L. 108–173, §237(b)(1), added par. (4).

Subsec. (b)(1). Pub. L. 108–173, §222(f)(1), amended heading and text of par. (1) generally, substituting provisions relating to announcements of payment rates for 2005 and for 2006 and subsequent years for provisions relating to announcement for years before 2004, for 2004 and 2005, and for years after 2005.

Subsec. (b)(1)(B)(iii). Pub. L. 108–173, §241(b)(1)(B), added cl. (iii).

Subsec. (b)(3). Pub. L. 108–173, §222(f)(2), substituted ''in such announcement'' for ''in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization''.

Subsec. (b)(4). Pub. L. 108–173, §900(e)(1)(G)(i), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration'' in introductory provisions.

Subsec. (c)(1). Pub. L. 108–173, §221(d)(4), inserted ''that is an MA local area'' after ''for a Medicare+Choice payment area'' in introductory provisions.

Pub. L. 108–173, §211(a)(2), substituted ''(C), or (D)'' for ''or (C)'' in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 108–173, §211(b)(1), (c)(1)(A), substituted ''For a year before 2005, the sum'' for ''The sum'' in introductory provisions and inserted ''(for a year other than 2004)'' after ''multiplied'' in concluding provisions.

Subsec. (c)(1)(B)(iv). Pub. L. 108–173, §211(c)(1)(B), substituted '', 2003, and 2004'' for ''and each succeeding year''.

Subsec. (c)(1)(C)(iv). Pub. L. 108–173, §211(c)(1)(C), substituted ''and 2003'' for ''and each succeeding year''.

Subsec. (c)(1)(C)(v). Pub. L. 108–173, §211(c)(1)(D), added cl. (v).

Subsec. (c)(1)(D). Pub. L. 108–173, §211(a)(1), added subpar. (D).

Subsec. (c)(3)(A). Pub. L. 108–173, §211(d)(1), substituted ''subparagraphs (B) and (E)'' for ''subparagraph (B)'' in introductory provisions.

Subsec. (c)(3)(E). Pub. L. 108–173, §211(d)(2), added subpar. (E).

Subsec. (c)(5). Pub. L. 108–173, §736(d)(1)(C), substituted ''(a)(3)(C)(iv)'' for ''(a)(3)(C)(iii)''.

Pub. L. 108–173, §237(b)(2)(B), substituted ''subsections (a)(3)(C)(iii), (a)(4), and (i)'' for ''subsections (a)(3)(C)(iii) and (i)''.

Pub. L. 108–173, § 211(b)(2), inserted ''(other than 2004)'' after ''for each year''.

Subsec. (c)(6)(C). Pub. L. 108–173, § 211(c)(2), inserted '', except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004'' before period at end.

Subsec. (c)(7). Pub. L. 108–173, § 900(e)(1)(G)(ii), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Subsec. (d). Pub. L. 108–173, § 221(d)(1)(A), substituted ''MA payment area; MA local area; MA region defined'' for '' 'Medicare+Choice payment area' defined'' in heading.

Subsec. (d)(1). Pub. L. 108–173, § 221(d)(1)(C), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''In this part, except as provided in paragraph (3), the term 'Medicare+Choice payment area' means a county, or equivalent area specified by the Secretary.''

Subsec. (d)(2), (3). Pub. L. 108–173, § 221(d)(1)(B), (D), added par. (2) and redesignated former par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (d)(4). Pub. L. 108–173, § 221(d)(1)(B), redesignated par. (3) as (4).

Subsec. (d)(4)(A). Pub. L. 108–173, § 221(d)(1)(E)(i), inserted ''for MA local plans'' after ''paragraph (1)'' in introductory provisions.

Subsec. (d)(4)(A)(iii). Pub. L. 108–173, § 221(d)(1)(E)(ii), substituted ''paragraph (1)(A)'' for ''paragraph (1)''.

Subsec. (d)(4)(B). Pub. L. 108–173, § 221(d)(1)(E)(iii), inserted ''with respect to MA local plans'' after ''established under this section'' and ''for such plans'' after ''payments under this section'' and ''made under this section''.

Subsec. (f). Pub. L. 108–173, § 101(e)(3)(D), in heading, substituted ''Trust Funds'' for ''Trust Fund'' and, after first sentence, inserted ''Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.''

Subsec. (g). Pub. L. 108–173, § 211(e)(1)(A), inserted '', a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title)'' after ''1395ww(d)(1)(B) of this title)'' in introductory provisions.

Subsec. (g)(2)(B). Pub. L. 108–173, § 211(e)(1)(B), inserted ''or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,'' after ''1395ww(d) of this title''.

Subsec. (j). Pub. L. 108–173, § 222(d), added subsec. (j).

Subsec. (j)(1)(A). Pub. L. 108–173, § 241(b)(1)(A), inserted ''subject to section 1395w–29(d)(2)(A) of this title,'' after ''within an MA local area,''.

2002—Subsec. (b)(1). Pub. L. 107–188 in introductory provisions substituted ''for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year'' for ''not later than March 1 before the calendar year concerned''.

2000—Subsec. (a)(1)(A). Pub. L. 106–554, § 1(a)(6) [title VI, § 606(a)(2)(A)], inserted ''reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and'' after ''for that area,''.

Subsec. (a)(1)(B). Pub. L. 106–554, § 1(a)(6) [title VI, § 605(a)], inserted at end ''In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.''

Subsec. (a)(3)(C)(ii). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(a)(1)], substituted ''Except as provided in clause (iii), such risk adjustment'' for ''Such risk adjustment''.

Subsec. (a)(3)(C)(ii)(I). Pub. L. 106–554, § 1(a)(6) [title VI, § 603(1)(A)], substituted ''and each succeeding year through 2003'' for ''and 2001'' and struck out ''and'' at end.

Subsec. (a)(3)(C)(ii)(II) to (V). Pub. L. 106–554, § 1(a)(6) [title VI, § 603(1)(B)], added subcls. (II) to (V) and struck out former subcl. (II) which read as follows: ''not more than 20 percent of such capitation rate in 2002.''

Subsec. (a)(3)(C)(iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(a)(2)], added cl. (iii) relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001.

Pub. L. 106–554, § 1(a)(6) [title VI, § 603(2)], added cl. (iii) relating to data for risk adjustment methodology.

Subsec. (c)(1)(B)(ii), (iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 601(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(B)(iv). Pub. L. 106–554, § 1(a)(6) [title VI, § 601(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted ''2002 and each succeeding year'' for ''a succeeding year'' and ''clause (iii)'' for ''clause (i)''.

Subsec. (c)(1)(C)(ii), (iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 602(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(C)(iv). Pub. L. 106–554, § 1(a)(6) [title VI, § 602(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted ''2002 and each succeeding year'' for ''a subsequent year''.

Subsec. (c)(5). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(b)], substituted ''subsections (a)(3)(C)(iii) and (i)'' for ''subsection (i)''.

Subsec. (c)(7). Pub. L. 106–554, § 1(a)(6) [title VI, § 611(a)], amended heading and text of par. (7) generally. Prior to amendment, text read as follows: ''If the Secretary makes a determination with respect to coverage under this subchapter that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part.''

Subsec. (i)(1). Pub. L. 106–554, § 1(a)(6) [title VI, § 608(a)], in introductory provisions, inserted '', or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001'' after ''January 1, 2000''.

1999—Subsec. (a)(1)(A). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(1)], substituted ''subsections (e), (g), and (i)'' for ''subsections (e) and (f)''.

Subsec. (a)(3)(C). Pub. L. 106–113, § 1000(a)(6) [title V, § 511(a)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (b)(4). Pub. L. 106–113, § 1000(a)(6) [title V, § 514(a)], added par. (4).

Subsec. (c)(5). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(2)], inserted ''(other than those attributable to subsection (i))'' after ''payments under this part''.

Subsec. (c)(6)(B)(v). Pub. L. 106–113, § 1000(a)(6) [title V, § 517], substituted ''0.3 percentage points'' for ''0.5 percentage points''.

Subsec. (i). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(3)], added subsec. (i).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable as if included in the enactment of Pub. L. 111–5, with certain exceptions, see section 602(d) of Pub. L. 114–113, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(e)(2), Dec. 8, 2003, 117 Stat. 2178, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning on or after January 1, 2004.''

Amendment by sections 221(d)(1), (4) and 222(d)–(f), (i) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 237(b)(1), (2)(B) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(d)(2), June 12, 2002, 116 Stat. 697, provided that: ''The amendment made by paragraph (1) [amending this section] shall first apply to announcements for years after 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §605(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to payments for months beginning with January 2002.''

Amendment by section 1(a)(6) [title VI, §606(a)(2)(A)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §608(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: ''The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of BBRA [Pub. L. 106–113, §1000(a)(6)].''

Amendment by section 1(a)(6) [title VI, §611(a)] of Pub. L. 106–554 effective Dec. 21, 2000, and applicable to national coverage determinations and legislative changes in benefits occurring on or after such date, see section 1(a)(6) [title VI, §611(c)] of Pub. L. 106–554, set out as a note under section 1395w–22 of this title.

REPORTS ON RISK ADJUSTMENT MODELS

Pub. L. 114–255, div. C, title XVII, §17006(f)(2)(A)(ii), Dec. 13, 2016, 130 Stat. 1337, provided that: ''Not later than December 31, 2018, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the risk adjustment model and the ESRD risk adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees.''

MEDPAC STUDY OF AAPCC

Pub. L. 108–173, title II, §211(f), Dec. 8, 2003, 117 Stat. 2178, directed the Medicare Payment Advisory Commission to conduct a study that would assess the method used for determining the adjusted average per capita cost (AAPCC) under section 1395mm(a)(4) of this title, as applied under subsection (c)(1)(A) of this section, and to submit to Congress a report on such study not later than 18 months after Dec. 8, 2003.

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(i), Dec. 8, 2003, 117 Stat. 2179, provided that:

''(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section [amending this section and section 1395w–22 of this title and enacting provisions set out as notes under this section and section 1395w–21 of this title].

''(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554, set out as a note under this section] (114 Stat. 2763A–555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section [amending this section] for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

''(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

''(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

''(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

''(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

''(4) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act [this part] that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w–23(a)(1) [1395w–24(a)(1)]) for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395*oo*), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection.''

SPECIAL RULE FOR JANUARY AND FEBRUARY OF 2001

Pub. L. 106–554, §1(a)(6) [title VI, §601(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554, provided that:

''(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2001, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, as if such amendments had not been enacted.

''(2) CONSTRUCTION.—Paragraph (1) shall not be taken into account in computing such capitation rate for 2002 and subsequent years.''

Pub. L. 106–554, §1(a)(6) [title VI, §602(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that: ''The provisions of section 601(b) [set out above] shall apply with respect to the amendments made by subsection (a) [amending this section] in the same manner as they apply to the amendments made by section 601(a) [amending this section].''

TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §604], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that:

''(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2001, revised in accordance with the provisions of this Act.

''(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act [Dec. 21, 2000] that it was terminating its contract under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it submits the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) within 2 weeks after the date revised rates are announced by the Secretary under subsection (a).

''(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

''(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act [this part] for all or part of the service area or areas served under its current contract, and

''(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, utilize the stabilization fund described in section 1854(f)(2) of such Act (42 U.S.C. 1395w–24(f)(2)), or stabilize or enhance beneficiary access to providers (so long as such stabilization or enhancement does not result in increased beneficiary premiums, increased beneficiary cost-sharing, or reduced benefits).

''(d) WAIVER OF LIMITS ON STABILIZATION FUND.—Any regulatory provision that limits the proportion of the excess amount that can be withheld in such stabilization fund for a contract period shall not apply with respect to submissions described in subsections (b) and (c).

''(e) DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w–23(b)).''

PUBLICATION

Pub. L. 106–554, §1(a)(6) [title VI, §605(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: ''Not later than 6 months after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b) [set out as a note above].''

REPORT ON INCLUSION OF CERTAIN COSTS OF THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES IN CALCULATING MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §609], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: ''The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs, and the costs of military facility services furnished by the Department of Defense, to medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by-county basis—

''(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

''(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

''(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

''(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program under title XVIII of the Social Security Act [this subchapter].''

MEDPAC STUDY AND REPORT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) and includes the issues described in paragraph (2).

''(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

''(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain

variations in plans' average per capita medicare costs, as reported by Medicare+Choice plans in the plans' adjusted community rate filings.

''(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

''(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

''(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

''(E) An evaluation of the exclusion of 'discretionary' hospitalizations from consideration in the risk adjustment methodology.

''(F) Suggestions for changes or improvements in the risk adjustment methodology.

''(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.''

STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–381, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

''(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

''(B) Establishing alternative risk adjustment methods that would require submission of less data.

''(C) The potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as 'coding creep') and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

''(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

''(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

''(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.''

SPECIAL RULE FOR 2001

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §514(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w–23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.''

DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

''(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

''(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

''(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.''

PUBLICATION OF NEW CAPITATION RATES

Pub. L. 105–33, title IV, §4002(i), Aug. 5, 1997, 111 Stat. 330, provided that: ''Not later than 4 weeks after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act [subsec. (b) of this section].''

MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §§4011, 4012, Aug. 5, 1997, 111 Stat. 334–336, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title V, §533], Nov. 29, 1999, 113 Stat. 1536, 1501A–389, provided that:

''SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

''(a) ESTABLISHMENT OF PROJECT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services (in this subchapter [subchapter A (§§4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33] referred to as the 'Secretary') shall establish a demonstration project (in this subchapter referred to as the 'project') under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

''(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

''(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

''(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the

project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

''(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

''(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

''(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).

''(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

''(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term 'Competitive Pricing Advisory Committee' means the Competitive Pricing Advisory Committee established under section 4012(a).

''(2) INITIAL DESIGNATION OF 4 AREAS.—

''(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

''(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

''(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

''(c) PROJECT IMPLEMENTATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

''(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

''(i) establish the benefit design among plans offered in such area,

''(ii) structure the method for selecting plans offered in such area; and

''(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

''(B) in consultation with such Committee—

''(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

''(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

''(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

''(d) MONITORING AND REPORT.—

''(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

''(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

''(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act [this subchapter] (as amended by this Act) as may be necessary for the purposes of carrying out the project.

''(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

''(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001 [enacting this part and redesignating former part C of this subchapter as part D], if the project had not been conducted.

''(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act [this part], as amended by section 4001, shall have the same meaning as when used in such part.

''SEC. 4012. ADVISORY COMMITTEES.

''(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

''(1) IN GENERAL.—Before implementing the project under this subchapter [subchapter A (§§ 4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33],

the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

''(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

''(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

''(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

''(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

''(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

''(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.''

§ 1395w–24. Premiums and bid amounts

(a) Submission of proposed premiums, bid amounts, and related information

(1) In general

(A) Initial submission

Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

(ii) The plan type for each plan.

(iii) The enrollment capacity (if any) in relation to the plan and area.

(B) Beneficiary rebate information

In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

(C) Paperwork reduction for offering of MA regional plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) Information required for coordinated care plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

(3) Requirements for MSA plans

For an MSA plan for any year, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the

Medicare+Choice monthly supplementary beneficiary premium.

(4) Requirements for private fee-for-service plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(C) of this title for benefits described in section 1395w–22(a)(1)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

(5) Review

(A) In general

Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under paragraphs (2) and (4) of this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare & Medicaid Services shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) Exception

The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or, in the case of an MA private fee-for-service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

(C) Rejection of bids

(i) In general

Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

(ii) Authority to deny bids that propose significant increases in cost sharing or decreases in benefits

The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(6) Submission of bid amounts by MA organizations beginning in 2006

(A) Information to be submitted

For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 300e–1(8) of this title) in the payment area for an enrollee with a national average risk profile for the factors described in section 1395w–23(a)(1)(C) of this title (as specified by the Secretary).

(ii) The proportions of such bid amount that are attributable to—

(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title), including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title;

(II) the provision of basic prescription drug coverage; and

(III) the provision of supplemental health care benefits.

(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A).

(v) With respect to qualified prescription drug coverage, the information required under section 1395w–104 of this title, as incorporated under section 1395w–111(b)(2) of this title, with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) Acceptance and negotiation of bid amounts

(i) Authority

Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel

Management with respect to health benefits plans under chapter 89 of title 5.

(ii) Application of FEHBP standard

Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8) of this title) of benefits provided under that plan.

(iii) Noninterference

In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

(iv) Exception

In the case of a plan described in section 1395w–21(a)(2)(C) of this title, the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

(b) Monthly premium charged

(1) In general

(A) Rule for other than MSA plans

Subject to the rebate under subparagraph (C), the monthly amount (if any) of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly supplementary beneficiary premium (if any), and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium.

(B) MSA plans

The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(C) Beneficiary rebate rule

(i) Requirement

The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent (or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012) of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

(ii) Form of rebate for plan years before 2012

For plan years before 2012, a rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

(I) Provision of supplemental health care benefits and payment for premium for supplemental benefits

The provision of supplemental health care benefits described in section 1395w–22(a)(3) of this title in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

(II) Payment for premium for prescription drug coverage

Crediting toward the MA monthly prescription drug beneficiary premium.

(III) Payment toward part B premium

Crediting toward the premium imposed under part B (determined without regard to the application of subsections (b), (h), and (i) of section 1395r of this title).

(iii) Applicable rebate percentage

The applicable rebate percentage specified in this clause for a plan for a year, based on the system under section 1395w–23(*o*)(4)(A), is the sum of—

(I) the product of the old phase-in proportion for the year under clause (iv) and 75 percent; and

(II) the product of the new phase-in proportion for the year under clause (iv) and the final applicable rebate percentage under clause (v).

(iv) Old and new phase-in proportions

For purposes of clause (iv)—

(I) for 2012, the old phase-in proportion is ⅔ and the new phase-in proportion is ⅓;

(II) for 2013, the old phase-in proportion is ⅓ and the new phase-in proportion is ⅔; and

(III) for 2014 and any subsequent year, the old phase-in proportion is 0 and the new phase-in proportion is 1.

(v) Final applicable rebate percentage

Subject to clause (vi), the final applicable rebate percentage under this clause is—

(I) in the case of a plan with a quality rating under such system of at least 4.5 stars, 70 percent;

(II) in the case of a plan with a quality rating under such system of at least 3.5 stars and less than 4.5 stars, 65 percent; and

(III) in the case of a plan with a quality rating under such system of less than 3.5 stars, 50 percent.

(vi) Treatment of low enrollment and new plans

For purposes of clause (v)—

(I) for 2012, in the case of a plan described in subclause (I) of subsection (*o*)(3)(A)(ii),[1] the plan shall be treated as having a rating of 4.5 stars; and

(II) for 2012 or a subsequent year, in the case of a new MA plan (as defined under subclause (III) of subsection (*o*)(3)(A)(iii)[2]) that is treated as a qualifying plan pursuant to subclause (I) of such subsection, the plan shall be treated as having a rating of 3.5 stars.

(vii) Disclosure relating to rebates

The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

(viii) Application of part B premium reduction

Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(2) Premium and bid terminology defined

For purposes of this part:

(A) MA monthly basic beneficiary premium

The term ''MA monthly basic beneficiary premium'' means, with respect to an MA plan—

(i) described in section 1395w–23(a)(1)(B)(i) of this title (relating to plans providing rebates), zero; or

(ii) described in section 1395w–23(a)(1)(B)(ii) of this title, the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j) of this title).

(B) MA monthly prescription drug beneficiary premium

The term ''MA monthly prescription drug beneficiary premium'' means, with respect to an MA plan, the base beneficiary premium (as determined under section 1395w–113(a)(2) of this title and as adjusted under section 1395w–113(a)(1)(B) of this title), less the amount of rebate credited toward such amount under subsection (b)(1)(C)(ii)(II).

(C) MA monthly supplemental beneficiary premium

(i) In general

The term ''MA monthly supplemental beneficiary premium'' means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under subsection (b)(1)(C)(ii)(I).

(ii) Application of MA monthly supplementary beneficiary premium

For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).[3]

(D) Medicare+Choice monthly MSA premium

The term ''Medicare+Choice monthly MSA premium'' means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

(E) Unadjusted MA statutory non-drug monthly bid amount

The term ''unadjusted MA statutory non-drug monthly bid amount'' means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title).

(3) Computation of average per capita monthly savings for local plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA local plan and year is computed as follows:

(A) Determination of statewide average risk adjustment for local plans

(i) In general

Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each State, the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that State for MA local plans.

(ii) Treatment of States for first year in which local plan offered

In the case of a State in which no MA local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors

[1] So in original. Probably means subclause (I) of section 1395w–23(*o*)(3)(A)(ii) of this title.

[2] So in original. Probably means subclause (II) of section 1395w–23(*o*)(3)(A)(iii) of this title.

[3] See References in Text note below.

applied to comparable States or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than States

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than States or on a plan-specific basis.

(B) Determination of risk adjusted benchmark and risk-adjusted bid for local plans

For each MA plan offered in a local area in a State, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(1) of this title) for the area by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA local plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(4) Computation of average per capita monthly savings for regional plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA regional plan and year is computed as follows:

(A) Determination of regionwide average risk adjustment for regional plans

(i) In general

The Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each MA region the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that region for MA regional plans.

(ii) Treatment of regions for first year in which regional plan offered

In the case of an MA region in which no MA regional plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable regions or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than regions

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than MA regions or on a plan-specific basis.

(B) Determination of risk-adjusted benchmark and risk-adjusted bid for regional plans

For each MA regional plan offered in a region, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(2) of this title) for the region by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA regional plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(c) Uniform premium and bid amounts

Except as permitted under section 1395w–27(i) of this title, the MA monthly bid amount submitted under subsection (a)(6), the amounts of the MA monthly basic, prescription drug, and supplemental beneficiary premiums, and the MA monthly MSA premium charged under subsection (b) of an MA organization under this part may not vary among individuals enrolled in the plan.

(d) Terms and conditions of imposing premiums

(1) In general

Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic, prescription drug, and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1395w–21(g)(3)(B)(i) of this title, and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Beneficiary's option of payment through withholding from social security payment or use of electronic funds transfer mechanism

In accordance with regulations, an MA organization shall permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(A) withholding from benefit payments in the manner provided under section 1395s of this title with respect to monthly premiums under section 1395r of this title;

(B) an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); or

(C) such other means as the Secretary may specify, including payment by an employer or under employment-based retiree health

coverage (as defined in section 1395w–132(c)(1) of this title) on behalf of an employee or former employee (or dependent).

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this subchapter and shall be paid to the MA organization involved. No charge may be imposed under an MA plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

(3) Information necessary for collection

In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

(A) by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium described in paragraph (4) owed by such enrollee for each month during the year, and other information determined appropriate by the Secretary, in consultation with the Commissioner of Social Security; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(4) Consolidated monthly beneficiary premium

In the case of an enrollee in an MA plan, the Secretary shall provide a mechanism for the consolidation of—

(A) the MA monthly basic beneficiary premium (if any);

(B) the MA monthly supplemental beneficiary premium (if any); and

(C) the MA monthly prescription drug beneficiary premium (if any).

(e) Limitation on enrollee liability

(1) For basic and additional benefits before 2006

For periods before 2006, in no event may—

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title of an organization with respect to required benefits described in section 1395w–22(a)(1)(A) of this title and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(2) For supplemental benefits before 2006

For periods before 2006, if the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title with respect to supplemental benefits described in section 1395w–22(a)(3) of this title, the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

(3) Determination on other basis

If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A), (2), or (4), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) Special rule for private fee-for-service plans and for basic benefits beginning in 2006

With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan) and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title, in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to benefits under the original medicare fee-for-service program option, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable with respect to such benefits on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits before 2006

(1) Requirement

(A) In general

For years before 2006, each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) Excess amount

For purposes of this paragraph, the ''excess amount'', for an organization for a plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1395w–23 of this title for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1395w–22(a)(1)(A) of this title under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

(C) Adjusted excess amount

For purposes of this paragraph, the ''adjusted excess amount'', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) Uniform application

This paragraph shall be applied uniformly for all enrollees for a plan.

(E) Premium reductions

(i) In general

Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1395w–23(a)(1)(A) of this title with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(ii) Amount of reduction

The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

(I) may not exceed 125 percent of the premium described under section 1395r(a)(3) of this title; and

(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

(F) Construction

Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1395w–22(a)(3) of this title) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) Stabilization fund

A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) Adjusted community rate

For purposes of this subsection, subject to paragraph (4), the term ''adjusted community rate'' for a service or services means, at the election of a Medicare+Choice organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a ''community rating system'' (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Determination based on insufficient data

For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) Prohibition of State imposition of premium taxes

No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1395w–23 of this title or premiums paid to such organizations under this part.

(h) Permitting use of segments of service areas

The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are com-

posed of one or more Medicare+Choice payment areas.

(Aug. 14, 1935, ch. 531, title XVIII, § 1854, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 308; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(C), title V, §§ 515(a), 516(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–384; Pub. L. 106–554, § 1(a)(6) [title VI, §§ 606(a)(1), 622(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557, 2763A–566; Pub. L. 107–188, title V, § 532(b)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title II, §§ 222(a)(1), (b), (c), (g), 232(b), title IX, § 900(e)(1)(H), Dec. 8, 2003, 117 Stat. 2193, 2196, 2199, 2203, 2208, 2371; Pub. L. 111–148, title III, §§ 3201(a)(2)(B), (c)–(d)(2), (e)(2)(A)(v), 3202(b)(1), (3), 3209(a), Mar. 23, 2010, 124 Stat. 444, 447, 454, 455, 460; Pub. L. 111–152, title I, § 1102(a), (d), Mar. 30, 2010, 124 Stat. 1040, 1045; Pub. L. 115–123, div. E, title III, § 50323(b), Feb. 9, 2018, 132 Stat. 203.)

Editorial Notes

References in Text

Cl. (iii) of par. (1)(C), referred to in subsec. (b)(2)(C)(ii), was struck out and a new cl. (iii) was added by Pub. L. 111–152, § 1102(d)(2). See 2010 Amendment note below. As so amended, par. (1)(C)(iii) no longer relates to purposes of rebates and no longer contains a subcl. (III).

Amendments

2018—Subsec. (a)(6)(A)(ii)(I). Pub. L. 115–123 inserted '', including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title'' before semicolon at end.

2010—Subsec. (a)(5)(C). Pub. L. 111–148, § 3209(a), added subpar. (C).

Subsec. (a)(6)(A). Pub. L. 111–148, § 3201(d)(1), which directed insertion of ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).'' at end of concluding provisions, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(i). Pub. L. 111–148, § 3201(d)(2)(A), which directed substitution of ''(iii), (iv), and (v)'' for ''(iii) and (iv)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(v). Pub. L. 111–148, § 3201(d)(2)(B), which directed addition of cl. (v), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1395w–23(j)(1)(A)(i) of this title, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

''(aa) actuarial guidelines for the submission of bid information under this paragraph; and

''(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

''(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

''(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(i). Pub. L. 111–152, § 1102(d)(1), inserted ''(or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012)'' after ''75 percent''.

Pub. L. 111–148, § 3201(c), which directed insertion of ''(or 100 percent in the case of plan years beginning on or after January 1, 2014)'' after ''75 percent'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(ii). Pub. L. 111–148, § 3202(b)(1)(A), substituted ''rebate for plan years before 2012'' for ''rebate'' in heading and ''For plan years before 2012, a rebate'' for ''A rebate'' in introductory provisions.

Subsec. (b)(1)(C)(iii). Pub. L. 111–152, § 1102(d)(2), added cl. (iii) and struck out former cl. (iii). Prior to amendment, text read as follows: ''For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

''(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

''(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

''(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).''

Pub. L. 111–148, § 3202(b)(1)(C), added cl. (iii).

Subsec. (b)(1)(C)(iv). Pub. L. 111–152, § 1102(d)(2), added cl. (iv). Former cl. (iv) redesignated (vii).

Pub. L. 111–148, § 3202(b)(1)(B), redesignated cl. (iii) as (iv).

Subsec. (b)(1)(C)(v). Pub. L. 111–152, § 1102(d)(2), added cl. (v). Former cl. (v) redesignated (viii).

Pub. L. 111–148, § 3202(b)(1)(B), redesignated cl. (iv) as (v).

Subsec. (b)(1)(C)(vi) to (viii). Pub. L. 111–152, § 1102(d)(2), added cl. (vi) and redesignated cls. (iv) and (v) as (vii) and (viii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, § 3202(b)(3), designated existing text as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (b)(3)(B)(i). Pub. L. 111–148, § 3201(a)(2)(B)(i), which directed substitution of ''1395w–23(j)(1)(A)'' for ''1395w–23(j)(1)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4)(B)(i). Pub. L. 111–148, § 3201(a)(2)(B)(ii), which directed substitution of ''1395w–23(j)(1)(B)'' for ''1395w–23(j)(2)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (h). Pub. L. 111–148, §3201(e)(2)(A)(v), which directed repeal of subsec. (h), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

2003—Pub. L. 108–173, §222(g)(1)(A), substituted ''Premiums and bid amounts'' for ''Premiums'' in section catchline.

Subsec. (a). Pub. L. 108–173, §222(g)(1)(B), inserted '', bid amounts,'' after ''premiums'' in heading.

Subsec. (a)(1). Pub. L. 108–173, §222(a)(1)(A), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year), each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h) of this section) in which it intends to be offered in the following year—

''(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

''(B) the enrollment capacity (if any) in relation to the plan and area.''

Subsec. (a)(2). Pub. L. 108–173, §222(g)(1)(C), inserted ''before 2006'' after ''for coordinated care plans'' in heading and ''for a year before 2006'' after ''section 1395w–21(a)(2)(A) of this title'' in introductory provisions.

Subsec. (a)(3). Pub. L. 108–173, §222(g)(1)(D), substituted ''For an MSA plan for any year'' for ''For an MSA plan described'' in introductory provisions.

Subsec. (a)(4). Pub. L. 108–173, §222(g)(1)(E), inserted ''before 2006'' after ''for private fee-for-service plans'' in heading and ''for a year before 2006'' after ''section 1395w–22(a)(1)(A) of this title'' in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 108–173, §900(e)(1)(H), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Pub. L. 108–173, §222(g)(1)(F), inserted ''paragraphs (2) and (4) of'' after ''filed under''.

Subsec. (a)(5)(B). Pub. L. 108–173, §222(g)(1)(G), inserted '', in the case of an MA private fee-for-service plan,'' after ''paragraph (3) or''.

Subsec. (a)(6). Pub. L. 108–173, §222(a)(1)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108–173, §222(b)(1)(A), (g)(1)(H), substituted ''Subject to the rebate under subparagraph (C), the monthly amount (if any)'' for ''The monthly amount'' and a comma for ''and'' after ''basic beneficiary premium'' and inserted before period at end '', and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium''.

Subsec. (b)(1)(C). Pub. L. 108–173, §222(b)(1)(B), added subpar. (C).

Subsec. (b)(2). Pub. L. 108–173, §222(b)(2), inserted ''and bid'' after ''Premium'' in heading, added subpars. (A) to (C) and (E), redesignated former subpar. (C) as (D), and struck out former subpars. (A) and (B) which defined the terms ''Medicare+Choice monthly basic beneficiary premium'' and ''Medicare+Choice monthly supplemental beneficiary premium''.

Subsec. (b)(3), (4). Pub. L. 108–173, §222(b)(3), added pars. (3) and (4).

Subsec. (c). Pub. L. 108–173, §222(g)(2), amended heading and text of subsec. (c) generally. Prior to amendment, text read as follows: ''The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of this section of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.''

Subsec. (d). Pub. L. 108–173, §222(c), (g)(3), designated existing provisions as par. (1), inserted heading and '', prescription drug,'' after ''basic'', and added pars. (2) to (4).

Subsec. (e)(1). Pub. L. 108–173, §222(g)(4)(A), inserted ''before 2006'' after ''benefits'' in heading and substituted ''For periods before 2006, in'' for ''In'' in introductory provisions.

Subsec. (e)(2). Pub. L. 108–173, §222(g)(4)(B), inserted ''before 2006'' after ''benefits'' in heading and substituted ''For periods before 2006, if'' for ''If'' in text.

Subsec. (e)(3). Pub. L. 108–173, §222(g)(4)(C), substituted '', (2), or (4)'' for ''or (2)''.

Subsec. (e)(4). Pub. L. 108–173, §222(g)(4)(D)(i), (ii), inserted ''and for basic benefits beginning in 2006'' after ''plans'' in heading and ''and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title'' after ''MSA plan)'' in introductory provisions.

Subsec. (e)(4)(A). Pub. L. 108–173, §222(g)(4)(D)(iii), substituted ''benefits under the original medicare fee-for-service program option'' for ''required benefits described in section 1395w–22(a)(1) of this title''.

Subsec. (e)(4)(B). Pub. L. 108–173, §222(g)(4)(D)(iv), inserted ''with respect to such benefits'' after ''would be applicable''.

Subsec. (f). Pub. L. 108–173, §222(g)(5)(A), inserted ''before 2006'' after ''additional benefits'' in heading.

Subsec. (f)(1)(A). Pub. L. 108–173, §222(g)(5)(B), substituted ''For years before 2006, each'' for ''Each''.

Subsec. (g). Pub. L. 108–173, §232(b), inserted ''or premiums paid to such organizations under this part'' after ''section 1395w–23 of this title''.

2002—Subsec. (a)(1). Pub. L. 107–188 substituted ''Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year)'' for ''Not later than July 1 of each year'' in introductory provisions.

2000—Subsec. (a)(5)(A). Pub. L. 106–554, §1(a)(6) [title VI, §622(a)], substituted ''values so submitted'' for ''value so submitted'' and inserted at end ''The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.''

Subsec. (f)(1)(E), (F). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(1)], added subpar. (E) and redesignated former subpar. (E) as (F).

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title V, §516(a)], substituted ''July 1'' for ''May 1'' in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title V, §515(a)(1)], inserted ''(or segment of such an area if permitted under subsection (h) of this section)'' after ''service area'' in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(i)(I)], inserted ''section'' before ''1395w–22(a)(1)(A) of this title'' in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(i)(II)], inserted ''section'' after ''described in'' in introductory provisions.

Subsec. (a)(3)(A), (B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(ii)], inserted ''section'' after ''described in''.

Subsec. (a)(4). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(I)], which directed insertion of ''section'' after ''described in'', was executed by making the insertion after ''described in'' the second time appearing in introductory provisions to reflect the probable intent of Congress.

Subsec. (a)(4)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(II)], inserted ''section'' after ''described in'' in introductory provisions.

Subsec. (a)(4)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(III)], inserted ''section'' after ''described in''.

Subsec. (h). Pub. L. 106–113, §1000(a)(6) [title V, §515(a)(2)], added subsec. (h).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate

transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

Pub. L. 111–148, title III, § 3201(d)(3), Mar. 23, 2010, 124 Stat. 445, which provided that amendments by section 3201(d) of Pub. L. 111–148 (amending this section) would apply to bid amounts submitted on or after Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.

Pub. L. 111–148, title III, § 3209(c), Mar. 23, 2010, 124 Stat. 460, provided that: ''The amendments made by this section [amending this section and section 1395w–111 of this title] shall apply to bids submitted for contract years beginning on or after January 1, 2011.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(a)(1), (b), (c), (g) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Pub. L. 108–173, title II, § 232(c), Dec. 8, 2003, 117 Stat. 2209, provided that: ''The amendments made by this subsection [probably should be ''this section'', amending this section and section 1395w–26 of this title] shall take effect on the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, § 532(b)(2), June 12, 2002, 116 Stat. 696, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to information submitted for years beginning with 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, § 606(a)(1)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, § 606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, § 1(a)(6) [title VI, § 622(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to submissions made on or after May 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(k)(6)(C)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 515(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''The amendments made by this section [amending this section] apply to contract years beginning on or after January 1, 2001.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 516(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''The amendment made by subsection (a) [amending this section] applies to information submitted by Medicare+Choice organizations for years beginning with 1999.''

§ 1395w–25. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations

(a) Organized and licensed under State law

(1) In general

Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

(2) Special exception for provider-sponsored organizations

(A) In general

In the case of a provider-sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) Failure to act on licensure application on a timely basis

The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before August 5, 1997, shall be included in determining such 90-day period.

(C) Denial of application based on discriminatory treatment

The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

(i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

(D) Denial of application based on application of solvency requirements

With respect to waiver applications filed on or after the date of publication of solvency standards under section 1395w–26(a) of this title, the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

(i) such requirements are not the same as the solvency standards established under section 1395w–26(a) of this title; or

(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to sol-

vency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this paragraph, the term ''solvency requirements'' means requirements relating to solvency and other matters covered under the standards established under section 1395w–26(a) of this title.

(E) Treatment of waiver

In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State—

(i) Limitation to State

The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) Limitation to 36-month period

The waiver shall be effective only for a 36-month period and may not be renewed.

(iii) Conditioned on compliance with consumer protection and quality standards

The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) Preemption of State law

Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) Prompt action on application

The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) Application and enforcement of State consumer protection and quality standards

(i) In general

A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

(I) would apply in the State to the organization if it were licensed under State law;

(II) are generally applicable to other Medicare+Choice organizations and plans in the State; and

(III) are consistent with the standards established under this part.

Such standards shall not include any standard preempted under section 1395w–26(b)(3)(B) of this title.

(ii) Incorporation into contract

In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1395w–27 of this title.

(iii) Enforcement

In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare+Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare+Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

(H) Report

By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long-term solvency of the program under this subchapter.

(3) Licensure does not substitute for or constitute certification

The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) Assumption of full financial risk

The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1395w–22(a)(1) of this title, except that the organization—

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of

the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(c) Certification of provision against risk of insolvency for unlicensed PSOs

(1) In general

Each Medicare+Choice organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1395w–26(a) of this title relating to the financial solvency and capital adequacy of the organization.

(2) Certification process for solvency standards for PSOs

The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

(d) "Provider-sponsored organization" defined

(1) In general

In this part, the term ''provider-sponsored organization'' means a public or private entity—

(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

(2) Substantial proportion

In defining what is a ''substantial proportion'' for purposes of paragraph (1)(B), the Secretary—

(A) shall take into account the need for such an organization to assume responsibility for providing—

(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

(3) Affiliation

For purposes of this subsection, a provider is ''affiliated'' with another provider if, through contract, ownership, or otherwise—

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

(D) both providers are part of an affiliated service group under section 414 of such Code.

(4) Control

For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(5) "Health care provider" defined

In this subsection, the term ''health care provider'' means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(6) Regulations

The Secretary shall issue regulations to carry out this subsection.

(Aug. 14, 1935, ch. 531, title XVIII, § 1855, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 312.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(3)(B), (D), is classified generally to Title 26, Internal Revenue Code.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

§ 1395w–26. Establishment of standards

(a) Establishment of solvency standards for provider-sponsored organizations

(1) Establishment

(A) In general

The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, standards described in section 1395w–25(c)(1) of this title (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) Factors to consider for solvency standards

In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

(C) Enrollee protection against insolvency

Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the organization's insolvency.

(2) Publication of notice

In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5 by not later than 45 days after August 5, 1997.

(3) Target date for publication of rule

As part of the notice under paragraph (2), and for purposes of this subsection, the ''target date for publication'' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) Abbreviated period for submission of comments

In applying section 564(c) of such title under this subsection, ''15 days'' shall be substituted for ''30 days''.

(5) Appointment of negotiated rulemaking committee and facilitator

The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) Preliminary committee report

The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) Final committee report

If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(8) Interim, final effect

The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) Publication of rule after public comment

The Secretary shall provide for consideration of such comments and republication of

such rule by not later than 1 year after the target date of publication.

(b) Establishment of other standards

(1) In general

The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(2) Use of current standards

Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1395mm of this title to carry out analogous provisions of such section.

(3) Relation to State laws

The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

(4) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1856, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 317; amended Pub. L. 106–554, § 1(a)(6) [title VI, §§ 612(a), 614(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560; Pub. L. 108–173, title II, § 232(a), Dec. 8, 2003, 117 Stat. 2208.)

Editorial Notes

AMENDMENTS

2003—Subsec. (b)(3). Pub. L. 108–173 reenacted heading without change and amended text generally. Prior to amendment, text consisted of subpars. (A) and (B) stating general rule and listing standards specifically superseded.

2000—Subsec. (b)(3)(B)(i). Pub. L. 106–554, § 1(a)(6) [title VI, § 614(a)(1)], inserted ''(including cost-sharing requirements)'' after ''Benefit requirements''.

Subsec. (b)(3)(B)(iv). Pub. L. 106–554, § 1(a)(6) [title VI, § 614(a)(2)], added cl. (iv).

Subsec. (b)(4). Pub. L. 106–554, § 1(a)(6) [title VI, § 612(a)], added par. (4).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title VI, § 612(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: ''The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, § 1(a)(6) [title VI, § 614(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–561, provided that: ''The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Dec. 21, 2000].''

§ 1395w–27. Contracts with Medicare+Choice organizations

(a) In general

The Secretary shall not permit the election under section 1395w–21 of this title of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w–23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) Minimum enrollment requirements

(1) In general

Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) Application to MSA plans

In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) Allowing transition

The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) Contract period and effectiveness

(1) Period

Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) Termination authority

In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) Effective date of contracts

The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) Previous terminations

(A) In general

The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) Earlier re-entry permitted where change in payment policy

Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1395w–23 of this title for that Medicare+Choice payment area.

(5) Contracting authority

The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(d) Protections against fraud and beneficiary protections

(1) Periodic auditing

The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1395w–27a(c) of this title) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) Inspection and audit

Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) Enrollee notice at time of termination

Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled with the organization under this part.

(4) Disclosure

(A) In general

Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary containing the information required to be reported under section 1320a–3 of this title by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

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

(B) "Party in interest" defined

For the purposes of this paragraph, the term ''party in interest'' means—

(i) any director, officer, partner, or employee responsible for management or ad-

ministration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) Access to information

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

(5) Loan information

The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(6) Review to ensure compliance with care management requirements for specialized Medicare Advantage plans for special needs individuals

In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1395w–28(f)(5) of this title.

(e) Additional contract terms

(1) In general

The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) Cost-sharing in enrollment-related costs

(A) In general

A Medicare+Choice organization and a PDP sponsor under part D shall pay the fee established by the Secretary under subparagraph (B).

(B) Authorization

The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D that is equal to the organization's or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1395w–21 of this title (relating to enrollment and dissemination of information), section 1395w–101(c) of this title, and section 1395b–4 of this title (relating to the health insurance counseling and assistance program).

(C) Authorization of appropriations

There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to $100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000, reduced by the amount of fees authorized to be collected under this paragraph and section 1395w–112(b)(3)(D) of this title for the fiscal year.

(D) Limitation

In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1395w–21 of this title and section 1395w–101(c) of this title and section 1395b–4 of this title; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000;

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and

(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) Medicare+Choice portion defined

In this paragraph, the term ''Medicare+Choice portion'' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(F) Applicable portion defined

In this paragraph, the term ''applicable portion'' means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this subchapter that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this subchapter that are attributable to expenditures made to such sponsors under part D.

(3) Agreements with federally qualified health centers

(A) Payment levels and amounts

A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1395w–23(a)(4) of this title between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) Cost-sharing

Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1395*l*(a)(3)(B) of this title as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1395w–24(e) of this title.

(4) Requirement for minimum medical loss ratio

If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

(A) the MA plan shall remit to the Secretary an amount equal to the product of—

(i) the total revenue of the MA plan under this part for the contract year; and

(ii) the difference between .85 and the medical loss ratio;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(5) Communicating plan corrective actions against opioids over-prescribers

(A) In general

Beginning with plan years beginning on or after January 1, 2021, a contract under this section with an MA organization shall require the organization to submit to the Secretary, through the process established under subparagraph (B), information on the investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier related to fraud, and other actions taken by such plans related to inappropriate prescribing of opioids.

(B) Process

Not later than January 1, 2021, the Secretary shall, in consultation with stakeholders, establish a process under which MA plans and prescription drug plans shall submit to the Secretary information described in subparagraph (A).

(C) Regulations

For purposes of this paragraph, including as applied under section 1395w–112(b)(3)(D) of this title, the Secretary shall, pursuant to rulemaking—

(i) specify a definition for the term ''inappropriate prescribing'' and a method for determining if a provider of services prescribes inappropriate prescribing; and

(ii) establish the process described in subparagraph (B) and the types of information that shall be submitted through such process.

(f) Prompt payment by Medicare+Choice organization

(1) Requirement

A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) Secretary's option to bypass noncomplying organization

In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(3) Incorporation of certain prescription drug plan contract requirements

The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to contracts with a PDP

sponsor offering a prescription drug plan under part D:

(A) Prompt payment

Section 1395w–112(b)(4) of this title.

(B) Submission of claims by pharmacies located in or contracting with long-term care facilities

Section 1395w–112(b)(5) of this title.

(C) Regular update of prescription drug pricing standard

Section 1395w–112(b)(6) of this title.

(D) Suspension of payments pending investigation of credible allegations of fraud by pharmacies

Section 1395w–112(b)(7) of this title.

(g) Intermediate sanctions

(1) In general

If the Secretary determines that a Medicare+Choice organization with a contract under this section—

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

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1395w–24 of this title;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1395w–22(j)(3) or 1395w–22(k)(2)(A)(ii) of this title;

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

(H) except as provided under subparagraph (C) or (D) of section 1395w–101(b)(1) of this title, enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1395w–21 of this title or applicable implementing regulations or guidance; or

(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.

(2) Remedies

The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, except with respect to a determination under subparagraph (E),[1] an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Other intermediate sanctions

In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under sub-

[1] So in original. Probably means subpar. (E) of par. (1).

section (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

(4) Civil money penalties

The provisions of section 1320a–7a (other than subsections (a) and (b)) of this title shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(h) Procedures for termination

(1) In general

The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) Exception for imminent and serious risk to health

Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(3) Delay in contract termination authority for plans failing to achieve minimum quality rating

During the period beginning on December 13, 2016, and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1395w–23(*o*)(4) of this title.

(i) Medicare+Choice program compatibility with employer or union group health plans

(1) Contracts with MA organizations

To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2) Employer sponsored MA plans

To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1395w–21(g) of this title, an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1857, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 319; amended Pub. L. 106–113, div. B, §1000(a)(6) [title V, §§513(a), (b)(1), 522(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–383, 1501A–387; Pub. L. 106–554, §1(a)(6) [title VI, §§617(a), 623(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–561, 2763A–566; Pub. L. 108–173, title II, §§222(j), (k), (*l*)(3)(C), 237(c), title IX, §900(e)(1)(I), Dec. 8, 2003, 117 Stat. 2205, 2207, 2213, 2372; Pub. L. 110–275, title I, §§164(d)(2), 171(b), 172(a)(2), 173(b), July 15, 2008, 122 Stat. 2574, 2580, 2581; Pub. L. 111–148, title VI, §6408(b), Mar. 23, 2010, 124 Stat. 771; Pub. L. 111–152, title I, §1103, Mar. 30, 2010, 124 Stat. 1047; Pub. L. 114–255, div. C, title XVII, §17001(b), Dec. 13, 2016, 130 Stat. 1330; Pub. L. 115–271, title II, §2008(b), title VI, §6063(b), Oct. 24, 2018, 132 Stat. 3931, 3988.)

Editorial Notes

AMENDMENTS

2018—Subsec. (e)(5). Pub. L. 115–271, §6063(b), added par. (5).

Subsec. (f)(3)(D). Pub. L. 115–271, §2008(b), added subpar. (D).

2016—Subsec. (h)(3). Pub. L. 114–255 added par. (3).

2010—Subsec. (d)(2)(A). Pub. L. 111–148, §6408(b)(1)(A), inserted ''timely'' before ''inspect''.

Subsec. (d)(2)(B). Pub. L. 111–148, §6408(b)(1)(B), inserted ''timely'' before ''audit and inspect''.

Subsec. (e)(4). Pub. L. 111–152 added par. (4).

Subsec. (g)(1). Pub. L. 111–148, § 6408(b)(2)(C), inserted at end of concluding provisions ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.''

Subsec. (g)(1)(H) to (K). Pub. L. 111–148, § 6408(b)(2), added subpars. (H) to (K).

Subsec. (g)(2)(A). Pub. L. 111–148, § 6408(b)(3), inserted ''except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

2008—Subsec. (d)(6). Pub. L. 110–275, § 164(d)(2), added par. (6).

Subsec. (f)(3). Pub. L. 110–275, § 171(b), added par. (3).

Subsec. (f)(3)(B). Pub. L. 110–275, § 172(a)(2), added subpar. (B).

Subsec. (f)(3)(C). Pub. L. 110–275, § 173(b), added subpar. (C).

2003—Subsec. (d)(1). Pub. L. 108–173, § 222(*l*)(3)(C), substituted ''and costs, including allowable costs under section 1395w–27a(c) of this title'' for '', costs, and computation of the adjusted community rate''.

Subsec. (d)(4)(A)(ii). Pub. L. 108–173, § 900(e)(1)(I), substituted ''Secretary'' for ''Health Care Financing Administration''.

Subsec. (e)(2)(A). Pub. L. 108–173, § 222(k)(1), inserted ''and a PDP sponsor under part D'' after ''organization''.

Subsec. (e)(2)(B). Pub. L. 108–173, § 222(k)(2), inserted ''and each PDP sponsor with a contract under part D'' after ''contract under this part'', ''or sponsor's'' after ''organization's'', and '', section 1395w–101(c) of this title,'' after ''information)''.

Subsec. (e)(2)(C). Pub. L. 108–173, § 222(k)(3), inserted ''and ending with fiscal year 2005'' after ''beginning with fiscal year 2001'', ''and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000,'' after ''$100,000,000,'', and ''and section 1395w–112(b)(3)(D) of this title'' after ''under this paragraph''.

Subsec. (e)(2)(D)(i). Pub. L. 108–173, § 222(k)(4)(A), inserted ''and section 1395w–101(c) of this title'' after ''section 1395w–21 of this title''.

Subsec. (e)(2)(D)(ii)(III). Pub. L. 108–173, § 222(k)(4)(B), struck out ''and'' at end.

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 108–173, § 222(k)(4)(C), substituted ''each succeeding fiscal year before fiscal year 2006; and'' for ''each succeeding fiscal year.''

Subsec. (e)(2)(D)(ii)(V). Pub. L. 108–173, § 222(k)(4)(D), added subcl. (V).

Subsec. (e)(2)(F). Pub. L. 108–173, § 222(k)(5), added subpar. (F).

Subsec. (e)(3). Pub. L. 108–173, § 237(c), added par. (3).

Subsec. (i). Pub. L. 108–173, § 222(j), designated existing provisions as par. (1), inserted heading, and added par. (2).

2000—Subsec. (g)(3)(D). Pub. L. 106–554, § 1(a)(6) [title VI, § 623(a)], added subpar. (D).

Subsec. (i). Pub. L. 106–554, § 1(a)(6) [title VI, § 617(a)], added subsec. (i).

1999—Subsec. (c)(4). Pub. L. 106–113, § 1000(a)(6) [title V, § 513(b)(1)(B), (C)], designated existing provisions as subpar. (A), inserted heading, realigned margins, and added subpar. (B).

Pub. L. 106–113, § 1000(a)(6) [title V, § 513(a), (b)(1)(A)], substituted ''2-year period'' for ''5-year period'' and ''except as provided in subparagraph (B) and except in such other circumstances'' for ''except in circumstances''.

Subsec. (e)(2)(B). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(1)], substituted ''Any amounts collected shall be available without further appropriation to the Secretary for'' for ''Any amounts collected are authorized to be appropriated only for''.

Subsec. (e)(2)(C). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(2)], amended heading and text of subpar. (C) generally. Prior to amendment, text read as follows: ''For any fiscal year, the fees authorized under subparagraph (B) are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in a fiscal year. Fees collected during any fiscal year under this paragraph shall be deposited and credited as offsetting collections.''

Subsec. (e)(2)(D)(ii)(II). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(3)(A)], struck out ''and'' after semicolon.

Subsec. (e)(2)(D)(ii)(III). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(3)(B)], substituted ''; and'' for ''and each subsequent fiscal year.''

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(3)(C)], added subcl. (IV).

Subsec. (e)(2)(E). Pub. L. 106–113, § 1000(a)(6) [title V, § 522(a)(4)], added subpar. (E).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, § 2008(e), Oct. 24, 2018, 132 Stat. 3931, provided that: ''The amendments made by this section [amending this section and sections 1395w–112 and 1395y of this title] shall apply with respect to plan years beginning on or after January 1, 2020.''

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6408(b)(1) of Pub. L. 111–148 effective Mar. 23, 2010, and amendment by section 6408(b)(2), (3) of Pub. L. 111–148 applicable to acts committed on or after Jan. 1, 2010, see section 6408(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, § 164(g), July 15, 2008, 122 Stat. 2575, provided that: ''The amendments made by subsections (c)(1), (d), and (e)(1) [amending this section and section 1395w–28 of this title] shall apply to plan years beginning on or after January 1, 2010, and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.].''

Pub. L. 110–275, title I, § 171(c), July 15, 2008, 122 Stat. 2580, provided that: ''The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2010.''

Pub. L. 110–275, title I, § 172(b), July 15, 2008, 122 Stat. 2581, provided that: ''The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2010.''

Pub. L. 110–275, title I, § 173(c), July 15, 2008, 122 Stat. 2581, provided that: ''The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2009.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(j), (k), (*l*)(3)(C) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 237(c) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §617(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–562, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to years beginning with 2001.''

Pub. L. 106–554, §1(a)(6) [title VI, §623(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to terminations occurring after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §513(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–383, provided that: ''The amendments made by this section [amending this section] apply to contract terminations occurring before, on, or after the date of the enactment of this Act [Nov. 29, 1999].''

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §522(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–387, provided that: ''The amendments made by subsection (a) [amending this section] apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period.''

CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §513(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–383, provided that: ''Nothing in the amendment made by paragraph (1)(C) [amending this section] shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).''

DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS

Pub. L. 114–255, div. C, title XVII, §17001(a), Dec. 13, 2016, 130 Stat. 1330, provided that: ''Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113–185) [see Tables for classification], it is the intent of Congress—

''(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

''(2) pending the results of such studies and input, to provide for a temporary delay in authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system.''

TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS

Pub. L. 111–148, title III, §3207, Mar. 23, 2010, 124 Stat. 459, provided that: ''For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject '2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.''

STUDY OF MULTI-YEAR CONTRACTS

Pub. L. 108–173, title I, §107(d), Dec. 8, 2003, 117 Stat. 2171, directed the Secretary of Health and Human Services to provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under this part and part D of this subchapter on a multi-year basis, and to submit to Congress a report on such study not later than Jan. 1, 2007.

IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS

Pub. L. 105–33, title IV, §4002(g), Aug. 5, 1997, 111 Stat. 330, provided that: ''Section 1857(e)(2) of the Social Security Act [42 U.S.C. 1395w–27(e)(2)] (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act [42 U.S.C. 1395w–21].''

§ 1395w–27a. Special rules for MA regional plans

(a) Regional service area; establishment of MA regions

(1) Coverage of entire MA region

The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1395w–24(h) of this title shall not apply to such a plan.

(2) Establishment of MA regions

(A) MA region

For purposes of this subchapter, the term ''MA region'' means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) Establishment

(i) Initial establishment

Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) Periodic review and revision of service areas

The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) Requirements for MA regions

The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) Number of regions

There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) Maximizing availability of plans

The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) Market survey and analysis

Before establishing MA regions, the Secretary shall conduct a market survey and

analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) National plan

Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

(b) Application of single deductible and catastrophic limit on out-of-pocket expenses

An MA regional plan shall include the following:

(1) Single deductible

Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

(2) Catastrophic limit

(A) In-network

A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

(B) Total

A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

(c) Portion of total payments to an organization subject to risk for 2006 and 2007

(1) Application of risk corridors

(A) In general

This subsection shall only apply to MA regional plans offered during 2006 or 2007.

(B) Notification of allowable costs under the plan

In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

(C) Allowable costs defined

For purposes of this subsection, the term ''allowable costs'' means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

(D) Rebatable integrated benefits

For purposes of this subsection, the term ''rebatable integrated benefits'' means such non-drug supplemental benefits under subclause (I) of section 1395w–24(b)(1)(C)(ii) of this title pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

(2) Adjustment of payment

(A) No adjustment if allowable costs within 3 percent of target amount

If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

(B) Increase in payment if allowable costs above 103 percent of target amount

(i) Costs between 103 and 108 percent of target amount

If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

(ii) Costs above 108 percent of target amount

If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

(C) Reduction in payment if allowable costs below 97 percent of target amount

(i) Costs between 92 and 97 percent of target amount

If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

(ii) Costs below 92 percent of target amount

If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

(D) Target amount described

For purposes of this paragraph, the term ''target amount'' means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

(i) the sum of—

(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title);

(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

(III) the total amount of the rebates under section 1395w–24(b)(1)(C)(ii) of this title that are attributable to rebatable integrated benefits; reduced by

(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

(3) Disclosure of information

(A) In general

Each contract under this part shall provide—

(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

(ii) that, pursuant to section 1395w–27(d)(2)(B) of this title, the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

(B) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

(d) Organizational and financial requirements

(1) In general

In the case of an MA organization that is offering an MA regional plan in an MA region and—

(A) meets the requirements of section 1395w–25(a)(1) of this title with respect to at least one such State in such region; and

(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

(2) Selection of appropriate State

In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1395w–25(a)(1) of this title with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

(e) Repealed. Pub. L. 111–148, title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 964

(f) Computation of applicable MA region-specific non-drug monthly benchmark amounts

(1) Computation for regions

For purposes of section 1395w–23(j)(2) of this title and this section, subject to subsection (e), the term ''MA region-specific non-drug monthly benchmark amount'' means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1395w–21(e)(3)(B) of this title for each year (beginning with 2006).

(2) 2 components

For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

(A) Statutory component

The product of the following:

(i) Statutory region-specific non-drug amount

The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

(ii) Statutory national market share

The statutory national market share percentage, determined under paragraph (4) for the year.

(B) Plan-bid component

The product of the following:

(i) Weighted average of MA plan bids in region

The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

(ii) Non-statutory market share

1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

(3) Statutory region-specific non-drug amount

For purposes of paragraph (2)(A)(i), the term ''statutory region-specific non-drug amount'' means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

(A) MA area-specific non-drug monthly benchmark amount under section 1395w–23(j)(1)(A) of this title for that area and year; and

(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

(4) Computation of statutory market share percentage

(A) In general

The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

(B) Reference month defined

For purposes of this part, the term ''reference month'' means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(5) Determination of weighted average MA bids for a region

(A) In general

For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) Monthly MA statutory non-drug bid amount

The unadjusted MA statutory non-drug monthly bid amount for the plan.

(ii) Plan's share of MA enrollment in region

The factor described in subparagraph (B) for the plan.

(B) Plan's share of MA enrollment in region

(i) In general

Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

(ii) Single plan rule

In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) Equal division among multiple plans in year in which plans are first available

In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) 1 divided by the number of such plans offered in such year; or

(II) a factor for such plan that is based upon the organization's estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(C) Counting of individuals

For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) Plans covered

For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) Election of uniform coverage determination

Instead of applying section 1395w–22(a)(2)(C) of this title with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) Assuring network adequacy

(1) In general

For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1395w–22 of this title with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1395ww of this title with respect to such services; and

(B) with respect to specific inpatient hospital services provided to an enrollee, the

hospital demonstrates to the satisfaction of the Secretary that the hospital's costs of such services exceed the payment amount described in subparagraph (A).

(2) Payment amounts

The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

(A) the amount of payment that would have been paid for such services under this subchapter if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

(B) the amount of payment made for such services under paragraph (1)(A).

(3) Available amounts

There shall be available for payments under this subsection—

(A) in 2006, $25,000,000; and

(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

(4) Essential hospital

In this subsection, the term ''essential hospital'' means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1395ww(d) of this title) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1858, as added Pub. L. 108–173, title II, § 221(c), Dec. 8, 2003, 117 Stat. 2181; amended Pub. L. 109–432, div. B, title III, § 301, Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, § 3, July 18, 2007, 121 Stat. 244; Pub. L. 110–173, title I, § 110, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, § 166, July 15, 2008, 122 Stat. 2575; Pub. L. 111–8, div. G, title I, § 1301(f), Mar. 11, 2009, 123 Stat. 829; Pub. L. 111–148, title III, § 3201(a)(2)(C), (f)(2), title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 444, 450, 964; Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.)

Editorial Notes

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–148, § 10327(c)(1), struck out subsec. (e) which related to the MA Regional Plan Stabilization Fund.

Subsec. (f)(1). Pub. L. 111–148, § 3201(a)(2)(C)(i), (f)(2)(A), which directed substitution of ''1395w–23(j)(1)(B)'' for ''1395w–23(j)(2)'' and ''subsections (e) and (i)'' for ''subsection (e)'', respectively, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (f)(3)(A). Pub. L. 111–148, § 3201(a)(2)(C)(ii), which directed substitution of ''1395w–23(j)(1)(A)(i)'' for ''1395w–23(j)(1)(A)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (i). Pub. L. 111–148, § 3201(f)(2)(B), which directed addition of subsec. (i), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows: ''For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1395w–23(n) of this title (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.'' See Effective Date of 2010 Amendment note below.

2009—Subsec. (e)(7). Pub. L. 111–8 struck out par. (7) which related to biennial GAO reports to be submitted by the Comptroller General to the Secretary and Congress.

2008—Subsec. (e)(2)(A)(i). Pub. L. 110–275 substituted ''2014'' for ''2013'' and ''$1'' for ''$1,790,000,000''.

2007—Subsec. (e)(2)(A)(i). Pub. L. 110–173, which directed substitution of ''the Fund during 2013, $1,790,000,000.'' for ''the Fund'' and all that follows, was executed by making the substitution for ''the Fund—

''(I) during 2012, $1,600,000,000; and

''(II) during 2013, $1,790,000,000.''

to reflect the probable intent of Congress.

Pub. L. 110–48 substituted ''the Fund—

''(I) during 2012, $1,600,000,000; and

''(II) during 2013, $1,790,000,000.''

for ''the Fund during the period beginning on January 1, 2012, and ending on December 31, 2013, a total of $3,500,000,000.''

2006—Subsec. (e)(2)(A)(i). Pub. L. 109–432 substituted ''2012'' for ''2007'' and ''$3,500,000,000'' for ''$10,000,000,000''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND; TRANSITION

Pub. L. 111–148, title X, § 10327(c)(2), Mar. 23, 2010, 124 Stat. 964, provided that: ''Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act [Mar. 23, 2010] shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.''

§ 1395w–28. Definitions; miscellaneous provisions

(a) Definitions relating to Medicare+Choice organizations

In this part—

(1) Medicare+Choice organization

The term ''Medicare+Choice organization'' means a public or private entity that is certified under section 1395w–26 of this title as meeting the requirements and standards of this part for such an organization.

(2) Provider-sponsored organization

The term ''provider-sponsored organization'' is defined in section 1395w–25(d)(1) of this title.

(b) Definitions relating to Medicare+Choice plans

(1) Medicare+Choice plan

The term ''Medicare+Choice plan'' means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1395w–27 of this title.

(2) Medicare+Choice private fee-for-service plan

The term ''Medicare+Choice private fee-for-service plan'' means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA plan

(A) In general

The term ''MSA plan'' means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1395w–22(a)(1) of this title in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

(B) Deductible

The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than $6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1395w–23(c)(6) of this title for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

(4) MA regional plan

The term ''MA regional plan'' means an MA plan described in section 1395w–21(a)(2)(A)(i) of this title—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA local plan

The term ''MA local plan'' means an MA plan that is not an MA regional plan.

(6) Specialized MA plans for special needs individuals

(A) In general

The term ''specialized MA plan for special needs individuals'' means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)) and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be.

(B) Special needs individual

The term ''special needs individual'' means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan under subchapter XIX; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions who—

(I) before January 1, 2022, have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care; and

(II) on or after January 1, 2022, have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits[1]

[1] So in original. Probably should be ''that are life threatening or significantly limit''.

overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under subsection (f)(9)(A).

The Secretary may apply rules similar to the rules of section 1395eee(c)(4) of this title for continued eligibility of special needs individuals.

(c) Other references to other terms

(1) Medicare+Choice eligible individual

The term ''Medicare+Choice eligible individual'' is defined in section 1395w–21(a)(3) of this title.

(2) Medicare+Choice payment area

The term ''Medicare+Choice payment area'' is defined in section 1395w–23(d) of this title.

(3) National per capita Medicare+Choice growth percentage

The ''national per capita Medicare+Choice growth percentage'' is defined in section 1395w–23(c)(6) of this title.

(4) Medicare+Choice monthly basic beneficiary premium; Medicare+Choice monthly supplemental beneficiary premium

The terms ''Medicare+Choice monthly basic beneficiary premium'' and ''Medicare+Choice monthly supplemental beneficiary premium'' are defined in section 1395w–24(a)(2) of this title.

(5) MA local area

The term ''MA local area'' is defined in section 1395w–23(d)(2) of this title.

(d) Coordinated acute and long-term care benefits under Medicare+Choice plan

Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under subchapter XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this subchapter and under such plan.

(e) Restriction on enrollment for certain Medicare+Choice plans

(1) In general

In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) Medicare+Choice religious fraternal benefit society plan described

For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1395w–21(a)(2) of this title that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) "Religious fraternal benefit society" defined

For purposes of paragraph (2)(A), a ''religious fraternal benefit society'' described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this subchapter who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) Payment adjustment

Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1395w–24 of this title as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) Requirements regarding enrollment in specialized MA plans for special needs individuals

(1) Requirements for enrollment

In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) Additional requirements for institutional SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual

requires an institutional level of care was made—

(i) using a State assessment tool of the State in which the individual resides; and

(ii) by an entity other than the organization offering the plan.

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(3) Additional requirements for dual SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals[2] described in subsection (b)(6)(B)(ii).

(B) The plan meets the requirements described in paragraph (5).

(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

(i) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under subchapter XIX; and

(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under subchapter XIX. Such benefits may include long-term care services consistent with State policy.

(E) If applicable, the plan meets the requirement described in paragraph (7).

(F) The plan meets the requirements applicable under paragraph (8).

(4) Additional requirements for severe or disabling chronic condition SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(5) Care management requirements for all SNPs

(A) In general

Subject to subparagraph (B), the requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals—

(i) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

(ii) with respect to each individual enrolled in the plan—

(I) conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs;

(II) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

(III) use an interdisciplinary team in the management of care.

(B) Improvements to care management requirements for severe or disabling chronic condition SNPs

For 2020 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the requirements described in this paragraph include the following:

(i) The interdisciplinary team under subparagraph (A)(ii)(III) includes a team of providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the plan.

(ii) Requirements developed by the Secretary to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis.

(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individual's individualized care plan under clause (ii)(II) of such subparagraph.

(iv) As part of the annual evaluation and approval of such model of care, the Secretary shall take into account whether the plan fulfilled the previous year's goals (as required under the model of care).

(v) The Secretary shall establish a minimum benchmark for each element of the model of care of a plan. The Secretary shall only approve a plan's model of care under this paragraph if each element of the model of care meets the minimum benchmark applicable under the preceding sentence.

(6) Transition and exception regarding restriction on enrollment

(A) In general

Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

(ii) the original medicare fee-for-service program under parts A and B.

(B) Applicable individuals

For purposes of clause (i), the term ''applicable individual'' means an individual who—

[2] So in original. Probably should be ''individual''.

(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) Exception

The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under subchapter XIX.

(D) Timeline for initial transition

The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) Authority to require special needs plans be NCQA approved

For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(8) Increased integration of dual SNPs

(A) Designated contact

The Secretary, acting through the Federal Coordinated Health Care Office established under section 1315b of this title, shall serve as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this paragraph and, consistent with such role, shall establish—

(i) a uniform process for disseminating to State Medicaid agencies information under this subchapter impacting contracts between such agencies and such plans under this subsection; and

(ii) basic resources for States interested in exploring such plans as a platform for integration, such as a model contract or other tools to achieve those goals.

(B) Unified grievances and appeals process

(i) In general

Not later than April 1, 2020, the Secretary shall establish procedures, to the extent feasible as determined by the Secretary, unifying grievances and appeals procedures under sections 1395w–22(f), 1395w–22(g), 1396a(a)(3), 1396a(a)(5), and 1396u–2(b)(4) of this title for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this subchapter and subchapter XIX. With respect to items and services described in the preceding sentence, procedures established under this clause shall apply in place of otherwise applicable grievances and appeals procedures. The Secretary shall solicit comment in developing such procedures from States, plans, beneficiaries and their representatives, and other relevant stakeholders.

(ii) Procedures

The procedures established under clause (i) shall be included in the plan contract under paragraph (3)(D) and shall—

(I) adopt the provisions for the enrollee that are most protective for the enrollee and, to the extent feasible as determined by the Secretary, are compatible with unified timeframes and consolidated access to external review under an integrated process;

(II) take into account differences in State plans under subchapter XIX to the extent necessary;

(III) be easily navigable by an enrollee; and

(IV) include the elements described in clause (iii), as applicable.

(iii) Elements described

Both unified appeals and unified grievance procedures shall include, as applicable, the following elements described in this clause:

(I) Single written notification of all applicable grievances and appeal rights under this subchapter and subchapter XIX. For purposes of this subparagraph, the Secretary may waive the requirements under section 1395w–22(g)(1)(B) of this title when the specialized MA plan covers items or services under this part or under subchapter XIX.

(II) Single pathways for resolution of any grievance or appeal related to a particular item or service provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this subchapter and subchapter XIX.

(III) Notices written in plain language and available in a language and format that is accessible to the enrollee, including in non-English languages that are prevalent in the service area of the specialized MA plan.

(IV) Unified timeframes for grievances and appeals processes, such as an individual's filing of a grievance or appeal, a plan's acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

(V) Requirements for how the plan must process, track, and resolve grievances and appeals, to ensure beneficiaries are notified on a timely basis of decisions that are made throughout the grievance or appeals process and are able to easily determine the status of a grievance or appeal.

(iv) Continuation of benefits pending appeal

The unified procedures under clause (i) shall, with respect to all benefits under parts A and B and subchapter XIX subject to appeal under such procedures, incorporate provisions under current law and implementing regulations that provide continuation of benefits pending appeal under this subchapter and subchapter XIX.

(C) Requirement for unified grievances and appeals

For 2021 and subsequent years, the contract of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under paragraph (3)(D) shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

(D) Requirements for integration

(i) In general

For 2021 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall meet one or more of the following requirements, to the extent permitted under State law, for integration of benefits under this subchapter and subchapter XIX:

(I) The specialized MA plan must meet the requirements of contracting with the State Medicaid agency described in paragraph (3)(D) in addition to coordinating long-term services and supports or behavioral health services, or both, by meeting an additional minimum set of requirements determined by the Secretary through the Federal Coordinated Health Care Office established under section 1315b of this title based on input from stakeholders, such as notifying the State in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees, assigning one primary care provider for each enrollee, or sharing data that would benefit the coordination of items and services under this subchapter and the State plan under subchapter XIX. Such minimum set of requirements must be included in the contract of the specialized MA plan with the State Medicaid agency under such paragraph.

(II) The specialized MA plan must meet the requirements of a fully integrated plan described in section 1395w–23(a)(1)(B)(iv)(II) of this title (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the PACE program), or enter into a capitated contract with the State Medicaid agency to provide long-term services and supports or behavioral health services, or both.

(III) In the case of a specialized MA plan that is offered by a parent organization that is also the parent organization of a Medicaid managed care organization providing long term services and supports or behavioral services under a contract under section 1396b(m) of this title, the parent organization must assume clinical and financial responsibility for benefits provided under this subchapter and subchapter XIX with respect to any individual who is enrolled in both the specialized MA plan and the Medicaid managed care organization.

(ii) Suspension of enrollment for failure to meet requirements during initial period

During the period of plan years 2021 through 2025, if the Secretary determines that a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) has failed to comply with clause (i), the Secretary may provide for the application against the Medicare Advantage organization offering the plan of the remedy described in section 1395w–27(g)(2)(B) of this title in the same manner as the Secretary may apply such remedy, and in accordance with the same procedures as would apply, in the case of an MA organization determined by the Secretary to have engaged in conduct described in section 1395w–27(g)(1) of this title. If the Secretary applies such remedy to a Medicare Advantage organization under the preceding sentence, the organization shall submit to the Secretary (at a time, and in a form and manner, specified by the Secretary) information describing how the plan will come into compliance with clause (i).

(E) Study and report to Congress

(i) In general

Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1395b–6 of this title, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1396 of this title, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1395w–22(e)(3) of this title (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) Additional reports

Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i).

(9) List of conditions for clarification of the definition of a severe or disabling chronic conditions specialized needs individual

(A) In general

Not later than December 31, 2020, and every 5 years thereafter, subject to subparagraphs (B) and (C), the Secretary shall convene a panel of clinical advisors to establish and update a list of conditions that meet each of the following criteria:

(i) Conditions that meet the definition of a severe or disabling chronic condition under subsection (b)(6)(B)(iii) on or after January 1, 2022.

(ii) Conditions that require prescription drugs, providers, and models of care that are unique to the specific population of enrollees in a specialized MA plan for special needs individuals described in such subsection on or after such date and—

(I) as a result of access to, and enrollment in, such a specialized MA plan for special needs individuals, individuals with such condition would have a reasonable expectation of slowing or halting the progression of the disease, improving health outcomes and decreasing overall costs for individuals diagnosed with such condition compared to available options of care other than through such a specialized MA plan for special needs individuals; or

(II) have a low prevalence in the general population of beneficiaries under this subchapter or a disproportionally high per-beneficiary cost under this subchapter.

(B) Inclusion of certain conditions

The conditions listed under subparagraph (A) shall include HIV/AIDS, end stage renal disease, and chronic and disabling mental illness.

(C) Requirement

In establishing and updating the list under subparagraph (A), the panel shall take into account the availability of varied benefits, cost-sharing, and supplemental benefits under the model described in paragraph (2) of section 1395w–28(h) of this title, including the expansion under paragraph (1) of such section.

(g) Special rules for senior housing facility plans

(1) In general

In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) Medicare Advantage senior housing facility plan described

For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1395w–22(*l*)(4)(B) of this title);

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

(h) National testing of Medicare Advantage Value-Based Insurance Design model

(1) In general

In implementing the Medicare Advantage Value-Based Insurance Design model that is being tested under section 1315a(b) of this title, the Secretary shall revise the testing of the model under such section to cover, effective not later than January 1, 2020, all States.

(2) Termination and modification provision not applicable until January 1, 2022

The provisions of section 1315a(b)(3)(B) of this title shall apply to the Medicare Advantage Value-Based Insurance Design model, including such model as revised under paragraph (1), beginning January 1, 2022, but shall not apply to such model, as so revised, prior to such date.

(3) Funding

The Secretary shall allocate funds made available under section 1315a(f)(1) of this title to design, implement, and evaluate the Medi-

care Advantage Value-Based Insurance Design model, as revised under paragraph (1).

(i) Program integrity transparency measures

(1) Program integrity portal

(A) In general

Not later than 2 years after October 24, 2018, the Secretary shall, after consultation with stakeholders, establish a secure internet website portal (or other successor technology) that would allow a secure path for communication between the Secretary, MA plans under this part, prescription drug plans under part D, and an eligible entity with a contract under section 1395ddd of this title (such as a Medicare drug integrity contractor or an entity responsible for carrying out program integrity activities under this part and part D) for the purpose of enabling through such portal (or other successor technology)—

(i) the referral by such plans of substantiated or suspicious activities, as defined by the Secretary, of a provider of services (including a prescriber) or supplier related to fraud, waste, and abuse for initiating or assisting investigations conducted by the eligible entity; and

(ii) data sharing among such MA plans, prescription drug plans, and the Secretary.

(B) Required uses of portal

The Secretary shall disseminate the following information to MA plans under this part and prescription drug plans under part D through the secure internet website portal (or other successor technology) established under subparagraph (A):

(i) Providers of services and suppliers that have been referred pursuant to subparagraph (A)(i) during the previous 12-month period.

(ii) Providers of services and suppliers who are the subject of an active exclusion under section 1320a–7 of this title or who are subject to a suspension of payment under this subchapter pursuant to section 1395y(*o*) of this title or otherwise.

(iii) Providers of services and suppliers who are the subject of an active revocation of participation under this subchapter, including for not satisfying conditions of participation.

(iv) In the case of such a plan that makes a referral under subparagraph (A)(i) through the portal (or other successor technology) with respect to activities of substantiated or suspicious activities of fraud, waste, or abuse of a provider of services (including a prescriber) or supplier, if such provider (including a prescriber) or supplier has been the subject of an administrative action under this subchapter or subchapter XI with respect to similar activities, a notification to such plan of such action so taken.

(C) Rulemaking

For purposes of this paragraph, the Secretary shall, through rulemaking, specify what constitutes substantiated or suspicious activities of fraud, waste, and abuse, using guidance such as what is provided in the Medicare Program Integrity Manual 4.8. In carrying out this subsection, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for substantiated fraud, waste, or abuse.

(D) HIPAA compliant information only

For purposes of this subsection, communications may only occur if the communications are permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(2) Quarterly reports

Beginning not later than 2 years after October 24, 2018, the Secretary shall make available to MA plans under this part and prescription drug plans under part D in a timely manner (but no less frequently than quarterly) and using information submitted to an entity described in paragraph (1) through the portal (or other successor technology) described in such paragraph or pursuant to section 1395ddd of this title, information on fraud, waste, and abuse schemes and trends in identifying suspicious activity. Information included in each such report shall—

(A) include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders; and

(B) be anonymized information submitted by plans without identifying the source of such information.

(3) Clarification

Nothing in this subsection shall preclude or otherwise affect referrals to the Inspector General of the Department of Health and Human Services or other law enforcement entities.

(Aug. 14, 1935, ch. 531, title XVIII, § 1859, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 325; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 523], Nov. 29, 1999, 113 Stat. 1536, 1501A–387; Pub. L. 108–173, title II, §§ 221(b)(1), (d)(2), 231(b), (c), Dec. 8, 2003, 117 Stat. 2180, 2193, 2207, 2208; Pub. L. 110–173, title I, § 108(a), Dec. 29, 2007, 121 Stat. 2496; Pub. L. 110–275, title I, §§ 162(b), 164(a), (c)(1), (d)(1), (e)(1), July 15, 2008, 122 Stat. 2571–2574; Pub. L. 111–148, title III, §§ 3205(a), (c), (e), (g), 3208(a), Mar. 23, 2010, 124 Stat. 457–459; Pub. L. 112–240, title VI, § 607, Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, § 1107, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, § 107, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, § 206, Apr. 16, 2015, 129 Stat. 145; Pub. L. 114–255, div. C, title XVII, § 17006(a)(2)(B), Dec. 13, 2016, 130 Stat. 1334; Pub. L. 115–123, div. E, title III, §§ 50311(a), (b)(1), (c), 50321, Feb. 9, 2018, 132 Stat. 192, 196, 200; Pub. L. 115–271, title VI, § 6063(a), Oct. 24, 2018, 132 Stat. 3987.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(3)(A), is classified generally to Title 26, Internal Revenue Code.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (i)(1)(D), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

AMENDMENTS

2018—Subsec. (b)(6)(B)(iii). Pub. L. 115–123, § 50311(c)(2)(A), substituted ''who—'' for ''who have'', inserted ''(I) before January 1, 2022, have'' before ''one or more comorbid and medically complex chronic conditions that are substantially disabling'', and added subcl. (II).

Subsec. (f)(1). Pub. L. 115–123, § 50311(a), struck out ''and for periods before January 1, 2019'' after ''the Secretary''.

Subsec. (f)(3)(F). Pub. L. 115–123, § 50311(b)(1)(A), added subpar. (F).

Subsec. (f)(5). Pub. L. 115–123, § 50311(c)(1), designated existing provisions as subpar. (A), inserted heading, substituted ''Subject to subparagraph (B), the requirements'' for ''The requirements'', redesignated former subpars. (A) and (B)(i) to (iii) as cls. (i) and (ii)(I) to (III), respectively, of subpar. (A), and added subpar. (B).

Subsec. (f)(8). Pub. L. 115–123, § 50311(b)(1)(B), added par. (8).

Subsec. (f)(9). Pub. L. 115–123, § 50311(c)(2)(B), added par. (9).

Subsec. (h). Pub. L. 115–123, § 50321, added subsec. (h).

Subsec. (i). Pub. L. 115–271 added subsec. (i).

2016—Subsec. (b)(6). Pub. L. 114–255 struck out ''may waive application of section 1395w–21(a)(3)(B) of this title in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and'' after ''The Secretary'' in concluding provisions.

2015—Subsec. (f)(1). Pub. L. 114–10 substituted ''2019'' for ''2017''.

2014—Subsec. (f)(1). Pub. L. 113–93 substituted ''2017'' for ''2016''.

2013—Subsec. (f)(1). Pub. L. 113–67 substituted ''2016'' for ''2015''.

Subsec. (f)(1). Pub. L. 112–240 substituted ''2015'' for ''2014''.

2010—Subsec. (f)(1). Pub. L. 111–148, § 3205(a), substituted ''2014'' for ''2011''.

Subsec. (f)(2)(C). Pub. L. 111–148, § 3205(e)(1), added subpar. (C).

Subsec. (f)(3)(E). Pub. L. 111–148, § 3205(e)(2), added subpar. (E).

Subsec. (f)(4)(C). Pub. L. 111–148, § 3205(e)(3), added subpar. (C).

Subsec. (f)(5). Pub. L. 111–148, § 3205(g), struck out ''described in subsection (b)(6)(B)(i)'' after ''individuals'' in introductory provisions.

Subsec. (f)(6), (7). Pub. L. 111–148, § 3205(c), (e)(4), added pars. (6) and (7).

Subsec. (g). Pub. L. 111–148, § 3208(a), added subsec. (g).

2008—Subsec. (b)(2). Pub. L. 110–275, § 162(b), inserted concluding provisions.

Subsec. (b)(6)(A). Pub. L. 110–275, § 164(c)(1)(A), inserted ''and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be'' before period at end.

Subsec. (b)(6)(B)(iii). Pub. L. 110–275, § 164(e)(1), inserted ''who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care'' before period at end.

Subsec. (f). Pub. L. 110–275, § 164(c)(1)(B)(ii), (iii), designated existing provisions as par. (1), inserted par. heading, and added pars. (2) to (4).

Pub. L. 110–275, § 164(c)(1)(B)(i), amended heading generally. Prior to amendment, heading read ''Restriction on enrollment for specialized MA plans for special needs individuals''.

Pub. L. 110–275, § 164(a), substituted ''2011'' for ''2010''.

Subsec. (f)(5). Pub. L. 110–275, § 164(d)(1), added par. (5).

2007—Subsec. (f). Pub. L. 110–173 substituted ''2010'' for ''2009''.

2003—Subsec. (b)(4), (5). Pub. L. 108–173, § 221(b)(1), added pars. (4) and (5).

Subsec. (b)(6). Pub. L. 108–173, § 231(b), added par. (6).

Subsec. (c)(5). Pub. L. 108–173, § 221(d)(2), added par. (5).

Subsec. (f). Pub. L. 108–173, § 231(c), added subsec. (f).

1999—Subsec. (e)(2). Pub. L. 106–113 substituted ''section 1395w–21(a)(2) of this title'' for ''section 1395w–21(a)(2)(A) of this title'' in introductory provisions.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(a)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, § 3208(b), Mar. 23, 2010, 124 Stat. 460, provided that: ''The amendment made by this section [amending this section] shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 164(c)(1), (d)(1), (e)(1) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, and applicable to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under this part, see section 164(g) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 221(b)(1), (d)(2) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 231(b), (c) of Pub. L. 108–173 effective Dec. 8, 2003, see section 231(f)(1) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

REGULATIONS

Pub. L. 108–173, title II, § 231(f)(2), Dec. 8, 2003, 117 Stat. 2208, provided that: ''No later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [42 U.S.C. 1395w–28(b)(6)(B)(iii)], as added by subsection (b).''

AUTHORIZATION TO OPERATE; RESOURCES FOR STATE MEDICAID AGENCIES; CONTRACTING REQUIREMENTS

Pub. L. 110–275, title I, § 164(c)(2)–(4), July 15, 2008, 122 Stat. 2573, as amended by Pub. L. 111–148, title III, § 3205(d), Mar. 23, 2010, 124 Stat. 458, provided that:

''(2) AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SNPS THAT DO NOT MEET CERTAIN RE-

QUIREMENTS.—Notwithstanding subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28), during the period beginning on January 1, 2010, and ending on December 31, 2012, in the case of a specialized Medicare Advantage plan for special needs individuals described in subsection (b)(6)(B)(ii) of such section, as amended by this section, that does not meet the requirement described in subsection (f)(3)(D) of such section, the Secretary of Health and Human Services—

''(A) shall permit such plan to be offered under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.]; and

''(B) shall not permit an expansion of the service area of the plan under such part C.

''(3) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

''(4) NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection [amending this section] shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.''

PANEL OF CLINICAL ADVISORS TO DETERMINE CONDITIONS

Pub. L. 110–275, title I, § 164(e)(2), July 15, 2008, 122 Stat. 2574, provided that: ''The Secretary of Health and Human Services shall convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling chronic conditions under section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)), as amended by paragraph (1). The panel shall include the Director of the Agency for Healthcare Research and Quality (or the Director's designee).''

NO EFFECT ON MEDICAID BENEFITS FOR DUALS

Pub. L. 110–275, title I, § 164(h), July 15, 2008, 122 Stat. 2575, provided that: ''Nothing in the provisions of, or amendments made by, this section [amending this section and sections 1395w–22 and 1395w–27 of this title and enacting provisions set out as notes under this section and sections 1395w–21, 1395w–22, and 1395w–27 of this title] shall affect the benefits available under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)).''

AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS

Secretary of Health and Human Services authorized, in promulgating regulations to carry out subsection (b)(6) of this section, to provide, notwithstanding subsection (b)(6)(A) of this section, for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals, see section 231(d) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

§ 1395w–29. Repealed. Pub. L. 111–152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046

Section, act Aug. 14, 1935, ch. 531, title XVIII, § 1860C–1, as added Pub. L. 108–173, title II, § 241(a), Dec. 8, 2003, 117 Stat. 2214; amended Pub. L. 111–148, title III, § 3201(a)(2)(D), Mar. 23, 2010, 124 Stat. 444; Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040, related to comparative cost adjustment program.

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

Editorial Notes

PRIOR PROVISIONS

A prior part D of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

SUBPART 1—PART D ELIGIBLE INDIVIDUALS AND PRESCRIPTION DRUG BENEFITS

§ 1395w–101. Eligibility, enrollment, and information

(a) Provision of qualified prescription drug coverage through enrollment in plans

(1) In general

Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1395w–102(a) of this title) as follows:

(A) Fee-for-service enrollees may receive coverage through a prescription drug plan

A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1395w–151(a)(14) of this title).

(B) Medicare Advantage enrollees

(i) Enrollees in a plan providing qualified prescription drug coverage receive coverage through the plan

A part D eligible individual who is enrolled in an MA–PD plan obtains such coverage through such plan.

(ii) Limitation on enrollment of MA plan enrollees in prescription drug plans

Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

(iii) Private fee-for-service enrollees in MA plans not providing qualified prescription drug coverage permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1395w–28(b)(2) of this title) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(iv) Enrollees in MSA plans permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MSA plan (as defined in section 1395w–28(b)(3) of this title) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(2) Coverage first effective January 1, 2006

Coverage under prescription drug plans and MA–PD plans shall first be effective on January 1, 2006.

(3) Definitions

For purposes of this part:

(A) Part D eligible individual

The term ''part D eligible individual'' means an individual who is entitled to benefits under part A or enrolled under part B (but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1395*o*(b) of this title).

(B) MA plan

The term ''MA plan'' has the meaning given such term in section 1395w–28(b)(1) of this title.

(C) MA–PD plan

The term ''MA–PD plan'' means an MA plan that provides qualified prescription drug coverage.

(b) Enrollment process for prescription drug plans

(1) Establishment of process

(A) In general

The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

(B) Application of MA rules

In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA–PD plan under the following provisions of section 1395w–21 of this title:

(i) Residence requirements

Section 1395w–21(b)(1)(A) of this title, relating to residence requirements.

(ii) Exercise of choice

Section 1395w–21(c) of this title (other than paragraph (3)(A) and paragraph (4) of such section), relating to exercise of choice.

(iii) Coverage election periods

Subject to paragraphs (2) and (3) of this subsection, section 1395w–21(e) of this title (other than subparagraphs (B), (C), (E), and (F) of paragraph (2) and the second sentence of paragraph (4) of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

(iv) Coverage periods

Section 1395w–21(f) of this title, relating to effectiveness of elections and changes of elections.

(v) Guaranteed issue and renewal

Section 1395w–21(g) of this title (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

(vi) Marketing material and application forms

Section 1395w–21(h) of this title, relating to approval of marketing material and application forms.

In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1395w–21(e) of this title shall be treated as a reference to such section as applied pursuant to clause (iii) of this subparagraph.

(C) Special rule

The process established under subparagraph (A) shall include, except as provided in subparagraph (D), in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1395w–114(a)(1)(A) of this title).[1] If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(D) Special rule for plans that waive de minimis premiums

The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1395w–114(a)(5) of this title. If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(2) Initial enrollment period

(A) Program initiation

In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1395w–21(e)(3)(B)(iii) of this title, as applied under paragraph (1)(B)(iii).

(B) Continuing periods

In the case of an individual who becomes a part D eligible individual after November 15, 2005, there shall be an initial enrollment period which is the period under section 1395w–21(e)(1) of this title, as applied under

[1] So in original. The closing parenthesis probably should not appear.

paragraph (1)(B)(iii) of this section,[2] as if ''entitled to benefits under part A or enrolled under part B'' were substituted for ''entitled to benefits under part A and enrolled under part B'', but in no case shall such period end before the period described in subparagraph (A).

(3) Additional special enrollment periods

The Secretary shall establish special enrollment periods, including the following:

(A) Involuntary loss of creditable prescription drug coverage

(i) In general

In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1395w–113(b)(4) of this title).

(ii) Notice

In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

(iii) Failure to pay premium

For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

(iv) Reduction in coverage

For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1395w–113(b)(5) of this title (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

(B) Errors in enrollment

In the case described in section 1395p(h) of this title (relating to errors in enrollment), in the same manner as such section applies to part B.

(C) Exceptional circumstances

In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

(D) Medicaid coverage

In the case of an individual (as determined by the Secretary, subject to such limits as the Secretary may establish for individuals identified pursuant to section 1395w–104(c)(5) of this title) who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title).

(E) Discontinuance of MA–PD election during first year of eligibility

In the case of a part D eligible individual who discontinues enrollment in an MA–PD plan under the second sentence of section 1395w–21(e)(4) of this title at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

[2] So in original. Probably should be ''of this subsection,''.

(4) Information to facilitate enrollment

(A) In general

Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA–PD plans to such individuals and enrollment of such individuals in such plans.

(B) Limitation

(i) Provision of information

The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

(ii) Use of information

Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA–PD plans.

(5) Reference to enrollment procedures for MA–PD plans

For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA–PD plans, see section 1395w–21 of this title.

(6) Reference to penalties for late enrollment

Section 1395w–113(b) of this title imposes a late enrollment penalty for part D eligible individuals who—

(A) enroll in a prescription drug plan or an MA–PD plan after the initial enrollment period described in paragraph (2); and

(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

(c) Providing information to beneficiaries

(1) Activities

The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior to the initial enrollment period described in subsection (b)(2)(A).

(2) Requirements

The activities described in paragraph (1) shall—

(A) be similar to the activities performed by the Secretary under section 1395w–21(d) of this title, including dissemination (including through the toll-free telephone number 1–800–MEDICARE) of comparative information for prescription drug plans and MA–PD plans; and

(B) be coordinated with the activities performed by the Secretary under such section and under section 1395b–2 of this title.

(3) Comparative information

(A) In general

Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

(i) Benefits

The benefits provided under the plan.

(ii) Monthly beneficiary premium

The monthly beneficiary premium under the plan.

(iii) Quality and performance

The quality and performance under the plan.

(iv) Beneficiary cost-sharing

The cost-sharing required of part D eligible individuals under the plan.

(v) Consumer satisfaction surveys

The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1395w–104(d) of this title.

(B) Exception for unavailability of information

The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

(i) for the first plan year in which it is offered; and

(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

(4) Information on late enrollment penalty

The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1395w–113(b) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–1, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2071; amended Pub. L. 109–432, div. B, title II, §206(b), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 111–148, title III, §3303(b), Mar. 23, 2010, 124 Stat. 469; Pub. L. 114–10, title II, §209(b)(2)(B)(ii), Apr. 16, 2015, 129 Stat. 149; Pub. L. 114–198, title VII, §704(a)(3), July 22, 2016, 130 Stat. 748; Pub. L. 116–260, div. CC, title IV, §402(g), Dec. 27, 2020, 134 Stat. 3002.)

Editorial Notes

AMENDMENTS

2020—Subsec. (a)(3)(A). Pub. L. 116–260 inserted ''(but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1395*o*(b) of this title)'' before period at end.

2016—Subsec. (b)(3)(D). Pub. L. 114–198 inserted '', subject to such limits as the Secretary may establish for individuals identified pursuant to section 1395w–104(c)(5) of this title'' after ''the Secretary''.

2015—Subsec. (b)(1)(B)(ii). Pub. L. 114–10, §209(b)(2)(B)(ii)(I), inserted ''and paragraph (4)'' after ''paragraph (3)(A)''.

Subsec. (b)(1)(B)(iii). Pub. L. 114–10, §209(b)(2)(B)(ii)(II), substituted ''(E), and (F)'' for ''and (E)''.

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §3303(b)(1), inserted ''except as provided in subparagraph (D),'' after ''shall include,''.

Subsec. (b)(1)(D). Pub. L. 111–148, §3303(b)(2), added subpar. (D).

2006—Subsec. (b)(1)(B)(iii). Pub. L. 109–432 substituted ''subparagraphs (B), (C), and (E)'' for ''subparagraphs (B) and (C)''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–198, title VII, §704(g)(1), July 22, 2016, 130 Stat. 751, provided that: ''The amendments made by this section [amending this section and sections 1395w–104, 1395w–152, 1395ddd, and 1395iii of this title] shall apply to prescription drug plans (and MA–PD plans) for plan years beginning on or after January 1, 2019.''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3303(c), Mar. 23, 2010, 124 Stat. 469, provided that: ''The amendments made by this subsection [probably should be ''this section'', amending this section and section 1395w–114 of this title] shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.''

REGULATIONS

Pub. L. 114–198, title VII, §704(g)(2), (3), July 22, 2016, 130 Stat. 751, 752, provided that:

''(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

''(A) IN GENERAL.—Not later than January 1, 2017, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled under part B of such title [42 U.S.C. 1395j et seq.], advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B). The input described in the preceding sentence shall be provided to the Secretary in sufficient time in order for the Secretary to take such input into account in promulgating the regulations pursuant to paragraph (3).

''(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

''(i) the anticipated impact of drug management programs for at-risk beneficiaries under paragraph (5) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors, and enrollees in MA–PD plans, who are at-risk beneficiaries for prescription drug abuse (as defined in subparagraph (C) of such paragraph);

''(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] that allow an automatic escalation to external review of claims submitted under such part);

''(iii) the types of enrollees that should be treated as exempted individuals, as described in subparagraph (C)(ii) of such paragraph;

''(iv) the manner in which terms and definitions in such paragraph should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph;

''(v) the information to be included in the notices described in subparagraph (B) of such paragraph and the standardization of such notices;

''(vi) with respect to a PDP sponsor (or Medicare Advantage organization) that establishes a drug management program for at-risk beneficiaries under such paragraph, the responsibilities of such PDP sponsor (or organization) with respect to the implementation of such program;

''(vii) notices for plan enrollees at the point of sale that would explain why an at-risk beneficiary has been prohibited from receiving a prescription at a location outside of the designated pharmacy;

''(viii) evidence-based prescribing guidelines for opiates; and

''(ix) the sharing of claims data under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] with PDP sponsors.

''(3) RULEMAKING.—Not later than one year after the date of the enactment of this Act [July 22, 2016], the Secretary of Health and Human Services shall, taking into account the input gathered pursuant to paragraph (2)(A) and after providing notice and an opportunity to comment, promulgate regulations to carry out the provisions of, and amendments made by[,] this section [amending this section and sections 1395w–104, 1395w–152, 1395ddd, and 1395iii of this title and enacting provisions set out as a note above].''

OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS

Pub. L. 111–148, title III, § 3313, Mar. 23, 2010, 124 Stat. 477, provided that:

''(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

''(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D [42 U.S.C. 1395w–101 et seq.] include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

''(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

''(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

''(1) STUDY.—

''(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] and for covered outpatient drugs under title XIX [42 U.S.C. 1396 et seq.]. Such study shall include the following:

''(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

''(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

''(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

''(ii) An assessment of—

''(I) the financial impact of any discrepancies in such prices on the Federal Government; and

''(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan under title XIX.

''(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

''(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

''(2) REPORT.—

''(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

''(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX [42 U.S.C. 1396 et seq.] to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

''(3) DEFINITIONS.—In this section:

''(A) COVERED PART D DRUG.—The term 'covered part D drug' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

''(B) COVERED OUTPATIENT DRUG.—The term 'covered outpatient drug' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r[–8](k)).

''(C) MA–PD PLAN.—The term 'MA–PD plan' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

''(D) MEDICARE ADVANTAGE ORGANIZATION.—The term 'Medicare Advantage organization' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)[sic](a)(1)).

''(E) PDP SPONSOR.—The term 'PDP sponsor' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

''(F) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).''

SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 108–173, title I, § 101(b), Dec. 8, 2003, 117 Stat. 2150, provided that: ''Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title and title II [see Tables for classification].''

STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE

Pub. L. 108–173, title I, § 101(c), Dec. 8, 2003, 117 Stat. 2150, provided that: ''Not later than January 1, 2005, the Secretary [of Health and Human Services] shall submit a report to Congress that makes recommendations regarding methods for providing benefits under subpart 1 of part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] for outpatient prescription drugs for which benefits are provided under part B of such title [42 U.S.C. 1395j et seq.].''

REPORT ON PROGRESS IN IMPLEMENTATION OF PRESCRIPTION DRUG BENEFIT

Pub. L. 108–173, title I, §101(d), Dec. 8, 2003, 117 Stat. 2150, provided that: ''Not later than March 1, 2005, the Secretary [of Health and Human Services] shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title [see Tables for classification]. The Secretary shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006. The report shall include recommendations regarding an appropriate transition from the program under section 1860D–31 of the Social Security Act [42 U.S.C. 1395w–141] to prescription drug benefits under subpart 1 of part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.].''

STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION

Pub. L. 108–173, title I, §106, Dec. 8, 2003, 117 Stat. 2168, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act [Dec. 8, 2003], a State Pharmaceutical Assistance Transition Commission (in this section referred to as the 'Commission') to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the voluntary prescription drug benefit program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.], as added by section 101.

''(2) DEFINITIONS.—For purposes of this section:

''(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term 'State pharmaceutical assistance program' means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act [Dec. 8, 2003] financial assistance to medicare beneficiaries for the purchase of prescription drugs.

''(B) PROGRAM PARTICIPANT.—The term 'program participant' means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

''(b) COMPOSITION.—The Commission shall include the following:

''(1) A representative of each Governor of each State that the Secretary [of Health and Human Services] identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under section 1860D–14 of the Social Security Act [42 U.S.C. 1395w–114].

''(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

''(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

''(4) Representatives of Medicare Advantage organizations, pharmaceutical benefit managers, and other private health insurance plans, as appointed by the Secretary.

''(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify.

The Secretary shall designate a member to serve as Chair of the Commission and the Commission shall meet at the call of the Chair.

''(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

''(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

''(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title [see Tables for classification].

''(3) Principles of medicare modernization under this Act [see Tables for classification].

''(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

''(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

''(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).''

CONFLICT OF INTEREST STUDY

Pub. L. 108–173, title I, §110, Dec. 8, 2003, 117 Stat. 2174, provided that:

''(a) STUDY.—The Federal Trade Commission shall conduct a study of differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers. Such study shall include the following:

''(1) An assessment of the differences in costs incurred by such enrollees and plans for prescription drugs dispensed by mail-order pharmacies owned by pharmaceutical benefit managers compared to mail-order pharmacies not owned by pharmaceutical benefit managers, and community pharmacies.

''(2) Whether such plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a report on the study conducted under subsection (a). Such report shall include recommendations regarding any need for legislation to ensure the fiscal integrity of the voluntary prescription drug benefit program under part D of title XVIII [42 U.S.C. 1395w–101 et seq.], as added by section 101, that may be appropriated as the result of such study.

''(c) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information under subsection (a).''

§ 1395w–102. Prescription drug benefits

(a) Requirements

(1) In general

For purposes of this part and part C, the term ''qualified prescription drug coverage'' means either of the following:

(A) Standard prescription drug coverage with access to negotiated prices

Standard prescription drug coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

(B) Alternative prescription drug coverage with at least actuarially equivalent benefits and access to negotiated prices

Coverage of covered part D drugs which meets the alternative prescription drug coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if the benefit design of such coverage is approved by the Secretary, as provided under subsection (c).

(2) Permitting supplemental prescription drug coverage

(A) In general

Subject to subparagraph (B), qualified prescription drug coverage may include supplemental prescription drug coverage consisting of either or both of the following:

(i) Certain reductions in cost-sharing

(I) In general

A reduction in the annual deductible, a reduction in the coinsurance percentage, or an increase in the initial coverage limit with respect to covered part D drugs, or any combination thereof, insofar as such a reduction or increase increases the actuarial value of benefits above the actuarial value of basic prescription drug coverage.

(II) Construction

Nothing in this paragraph shall be construed as affecting the application of subsection (c)(3).

(ii) Optional drugs

Coverage of any product that would be a covered part D drug but for the application of subsection (e)(2)(A).

(B) Requirement

A PDP sponsor may not offer a prescription drug plan that provides supplemental prescription drug coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a prescription drug plan in the area that only provides basic prescription drug coverage.

(3) Basic prescription drug coverage

For purposes of this part and part C, the term ''basic prescription drug coverage'' means either of the following:

(A) Coverage that meets the requirements of paragraph (1)(A).

(B) Coverage that meets the requirements of paragraph (1)(B) but does not have any supplemental prescription drug coverage described in paragraph (2)(A).

(4) Application of secondary payor provisions

The provisions of section 1395w–22(a)(4) of this title shall apply under this part in the same manner as they apply under part C.

(5) Construction

Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(4).

(b) Standard prescription drug coverage

For purposes of this part and part C, the term ''standard prescription drug coverage'' means coverage of covered part D drugs that meets the following requirements:

(1) Deductible

(A) In general

The coverage has an annual deductible—

(i) for 2006, that is equal to $250; or

(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (6) for the year involved.

(B) Rounding

Any amount determined under subparagraph (A)(ii) that is not a multiple of $5 shall be rounded to the nearest multiple of $5.

(2) Benefit structure

(A) 25 percent coinsurance

Subject to subparagraphs (C) and (D), the coverage has coinsurance (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

(i) equal to 25 percent; or

(ii) actuarially equivalent (using processes and methods established under section 1395w–111(c) of this title) to an average expected payment of 25 percent of such costs.

(B) Use of tiers

Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraphs (A)(ii), (C), and (D).

(C) Coverage for generic drugs in coverage gap

(i) In general

Except as provided in paragraph (4), the coverage for an applicable beneficiary (as defined in section 1395w–114a(g)(1) of this title) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for covered part D drugs that are not applicable drugs under section 1395w–114a(g)(2) of this title that is—

(I) equal to the generic-gap coinsurance percentage (specified in clause (ii)) for the year; or

(II) actuarially equivalent (using processes and methods established under section 1395w–111(c) of this title) to an average expected payment of such percentage of such costs for covered part D drugs that are not applicable drugs under section 1395w–114a(g)(2) of this title.

(ii) Generic-gap coinsurance percentage

The generic-gap coinsurance percentage specified in this clause for—

(I) 2011 is 93 percent;

(II) 2012 and each succeeding year before 2020 is the generic-gap coinsurance percentage under this clause for the previous year decreased by 7 percentage points; and

(III) 2020 and each subsequent year is 25 percent.

(D) Coverage for applicable drugs in coverage gap

(i) In general

Except as provided in paragraph (4), the coverage for an applicable beneficiary (as defined in section 1395w–114a(g)(1) of this

title) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for the negotiated price (as defined in section 1395w–114a(g)(6) of this title) of covered part D drugs that are applicable drugs under section 1395w–114a(g)(2) of this title that is—

(I) equal to the difference between—

(aa) the applicable gap percentage (specified in clause (ii) for the year); and

(bb) the discount percentage specified in section 1395w–114a(g)(4)(A) of this title for such applicable drugs (or, in the case of a year after 2018, 50 percent); or

(II) actuarially equivalent (using processes and methods established under section 1395w–111(c) of this title) to an average expected payment of such percentage of such costs, for covered part D drugs that are applicable drugs under section 1395w–114a(g)(2) of this title.

(ii) Applicable gap percentage

The applicable gap percentage specified in this clause for—

(I) 2013 and 2014 is 97.5 percent;

(II) 2015 and 2016 is 95 percent;

(III) 2017 is 90 percent;

(IV) 2018 is 85 percent; and

(V) 2019 and each subsequent year is 75 percent.

(3) Initial coverage limit

(A) In general

Except as provided in paragraphs (2)(C), (2)(D), and (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

(i) for 2006, that is equal to $2,250; or

(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(B) Rounding

Any amount determined under subparagraph (A)(ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(4) Protection against high out-of-pocket expenditures

(A) In general

(i) In general

The coverage provides benefits, after the part D eligible individual has incurred costs (as described in subparagraph (C)) for covered part D drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B), with cost-sharing that is equal to the greater of—

(I) a copayment of $2 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title) and $5 for any other drug; or

(II) coinsurance that is equal to 5 percent.

(ii) Adjustment of amount

For a year after 2006, the dollar amounts specified in clause (i)(I) shall be equal to the dollar amounts specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved. Any amount established under this clause that is not a multiple of a 5 cents shall be rounded to the nearest multiple of 5 cents.

(B) Annual out-of-pocket threshold

(i) In general

For purposes of this part, the ''annual out-of-pocket threshold'' specified in this subparagraph—

(I) for 2006, is equal to $3,600;

(II) for each of years 2007 through 2013, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved;

(III) for 2014 and 2015, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved, minus 0.25 percentage point;

(IV) for each of years 2016 through 2019, is equal to the amount specified in this subparagraph for the previous year, increased by the lesser of—

(aa) the annual percentage increase described in paragraph (7) for the year involved, plus 2 percentage points; or

(bb) the annual percentage increase described in paragraph (6) for the year;

(V) for 2020, is equal to the amount that would have been applied under this subparagraph for 2020 if the amendments made by section 1101(d)(1) of the Health Care and Education Reconciliation Act of 2010 had not been enacted; or

(VI) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(ii) Rounding

Any amount determined under clause (i)(II) that is not a multiple of $50 shall be rounded to the nearest multiple of $50.

(C) Application

Except as provided in subparagraph (E), in applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or

treated as being included) in the plan's formulary;

(ii) subject to clause (iii), such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual) and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs; and

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

(I) under section 1395w–114 of this title;

(II) under a State Pharmaceutical Assistance Program;

(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 1603 of title 25); or

(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act [42 U.S.C. 300ff–21 et seq.].

(D) Information regarding third-party reimbursement

(i) Procedures for exchanging information

In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

(I) for determining whether costs for part D eligible individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement; and

(II) for alerting the PDP sponsors and MA organizations that offer the prescription drug plans and MA–PD plans in which such individuals are enrolled about such reimbursement arrangements.

(ii) Authority to request information from enrollees

A PDP sponsor or an MA organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA–PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds for termination of enrollment in any plan under section 1395w–21(g)(3)(B) of this title (and as applied under this part under section 1395w–101(b)(1)(B)(v) of this title) for a period specified by the Secretary.

(E) Inclusion of costs of applicable drugs under medicare coverage gap discount program

In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1395w–114a(g) of this title) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1395w–114a of this title, regardless of whether part of such costs were paid by a manufacturer under such program, except that incurred costs shall not include the portion of the negotiated price that represents the reduction in coinsurance resulting from the application of paragraph (2)(D).

(5) Construction

Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization offering an MA–PD plan from reducing to zero the cost-sharing otherwise applicable to preferred or generic drugs.

(6) Annual percentage increase

The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.

(7) Additional annual percentage increase

The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending in July of the previous year.

(c) Alternative prescription drug coverage requirements

A prescription drug plan or an MA–PD plan may provide a different prescription drug benefit design from standard prescription drug coverage so long as the Secretary determines (consistent with section 1395w–111(c) of this title) that the following requirements are met and the plan applies for, and receives, the approval of the Secretary for such benefit design:

(1) Assuring at least actuarially equivalent coverage

(A) Assuring equivalent value of total coverage

The actuarial value of the total coverage is at least equal to the actuarial value of standard prescription drug coverage.

(B) Assuring equivalent unsubsidized value of coverage

The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by

which the actuarial value of the coverage exceeds the actuarial value of the subsidy payments under section 1395w–115 of this title with respect to such coverage.

(C) Assuring standard payment for costs at initial coverage limit

The coverage is designed, based upon an actuarially representative pattern of utilization, to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3) for the year, of an amount equal to at least the product of—

(i) the amount by which the initial coverage limit described in subsection (b)(3) for the year exceeds the deductible described in subsection (b)(1) for the year; and

(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2)(A)(i).

(2) Maximum required deductible

The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

(3) Same protection against high out-of-pocket expenditures

The coverage provides the coverage required under subsection (b)(4).

(d) Access to negotiated prices

(1) Access

(A) In general

Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)).

(B) Negotiated prices

For purposes of this part, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

(C) Medicaid-related provisions

The prices negotiated by a prescription drug plan, by an MA–PD plan with respect to covered part D drugs, or by a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title) with respect to such drugs on behalf of part D eligible individuals, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1396r–8(c)(1)(C) of this title.

(2) Disclosure

A PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall disclose to the Secretary (in a manner specified by the Secretary) the aggregate negotiated price concessions described in paragraph (1)(B) made available to the sponsor or organization by a manufacturer which are passed through in the form of lower subsidies, lower monthly beneficiary prescription drug premiums, and lower prices through pharmacies and other dispensers. The provisions of section 1396r–8(b)(3)(D) of this title apply to information disclosed to the Secretary under this paragraph.

(3) Audits

To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1395w–27(d)(2)(B) of this title (as applied under section 1395w–112(b)(3)(C) of this title), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans.

(e) Covered part D drug defined

(1) In general

Except as provided in this subsection, for purposes of this part, the term ''covered part D drug'' means—

(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1396r–8(k)(2) of this title; or

(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary),

and such term includes a vaccine licensed under section 262 of this title (and, for vaccines administered on or after January 1, 2008, its administration) and any use of a covered part D drug for a medically accepted indication (as defined in paragraph (4)).

(2) Exclusions

(A) In general

Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1396r–8(d)(2) of this title, other than subparagraph (E) of such section (relating to smoking cessation agents), other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines), or under section 1396r–8(d)(3) of this title, as such sections were in effect on December 8, 2003. Such term also does not include a drug when used for the treatment of sexual or erectile dysfunction, unless such drug were used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration.

(B) Medicare covered drugs

A drug prescribed for a part D eligible individual that would otherwise be a covered part D drug under this part shall not be so considered if payment for such drug as so prescribed and dispensed or administered with respect to that individual is available (or would be available but for the application of a deductible) under part A or B for that individual.

(3) Application of general exclusion provisions

A prescription drug plan or an MA–PD plan may exclude from qualified prescription drug coverage any covered part D drug—

(A) for which payment would not be made if section 1395y(a) of this title applied to this part; or

(B) which is not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to subsections (g) and (h), respectively, of section 1395w–104 of this title.

(4) Medically accepted indication defined

(A) In general

For purposes of paragraph (1), the term ''medically accepted indication'' has the meaning given that term—

(i) in the case of a covered part D drug used in an anticancer chemotherapeutic regimen, in section 1395x(t)(2)(B) of this title, except that in applying such section—

(I) ''prescription drug plan or MA–PD plan'' shall be substituted for ''carrier'' each place it appears; and

(II) subject to subparagraph (B), the compendia described in section 1396r–8(g)(1)(B)(i)(III) of this title shall be included in the list of compendia described in clause (ii)(I) section 1395x(t)(2)(B) of this title; and

(ii) in the case of any other covered part D drug, in section 1396r–8(k)(6) of this title.

(B) Conflict of interest

On and after January 1, 2010, subparagraph (A)(i)(II) shall not apply unless the compendia described in section 1396r–8(g)(1)(B)(i)(III) of this title meets[1] the requirement in the third sentence of section 1395x(t)(2)(B) of this title.

(C) Update

For purposes of applying subparagraph (A)(ii), the Secretary shall revise the list of compendia described in section 1396r–8(g)(1)(B)(i) of this title as is appropriate for identifying medically accepted indications for drugs. Any such revision shall be done in a manner consistent with the process for revising compendia under section 1395x(t)(2)(B) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–2, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2075; amended Pub. L. 109–91, title I, § 103(a), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–432, div. B, title II, § 202(b), Dec. 20, 2006, 120 Stat. 2986; Pub. L. 110–275, title I, §§ 175(a), 182(a)(1), July 15, 2008, 122 Stat. 2581, 2583; Pub. L. 111–148, title III, §§ 3301(c)(1), 3314(a), 3315, Mar. 23, 2010, 124 Stat. 467, 478, 479; Pub. L. 111–152, title I, § 1101(a)(2), (b)(3), (d), Mar. 30, 2010, 124 Stat. 1037–1039; Pub. L. 115–123, div. E, title XII, § 53116(a), Feb. 9, 2018, 132 Stat. 306.)

[1] So in original. Probably should be ''meet''.

Editorial Notes

REFERENCES IN TEXT

Section 1101(d)(1) of the Health Care and Education Reconciliation Act of 2010, referred to in subsec. (b)(4)(B)(i)(V), is section 1101(d)(1) of Pub. L. 111–152, which amended this section.

The Public Health Service Act, referred to in subsec. (b)(4)(C)(iii)(IV), is act July 1, 1944, ch. 373, 58 Stat. 682. Part B of title XXVI of the Act is classified generally to part B (§ 300ff–21 et seq.) of subchapter XXIV of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

2018—Subsec. (b)(2)(D)(i)(I). Pub. L. 115–123, § 53116(a)(1), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: ''equal to the difference between the applicable gap percentage (specified in clause (ii) for the year) and the discount percentage specified in section 1395w–114a(g)(4)(A) of this title for such applicable drugs; or''.

Subsec. (b)(2)(D)(ii)(V), (VI). Pub. L. 115–123, § 53116(a)(2), substituted ''2019'' for ''2020'' in subcl. (VI), redesignated subcl. (VI) as (V), and struck out former subcl. (V) which read as follows: ''2019 is 80 percent; and''.

2010—Subsec. (b)(2)(A). Pub. L. 111–152, § 1101(b)(3)(A), substituted ''Subject to subparagraphs (C) and (D), the coverage'' for ''The coverage''.

Subsec. (b)(2)(B). Pub. L. 111–152, § 1101(b)(3)(B), substituted ''subparagraphs (A)(ii), (C), and (D)'' for ''subparagraph (A)(ii)''.

Subsec. (b)(2)(C), (D). Pub. L. 111–152, § 1101(b)(3)(C), added subpars. (C) and (D).

Subsec. (b)(3)(A). Pub. L. 111–152, § 1101(b)(3)(D), substituted ''paragraphs (2)(C), (2)(D), and (4)'' for ''paragraph (4)''.

Pub. L. 111–148, § 3315(1), which directed substitution of ''paragraphs (4) and (7)'' for ''paragraph (4)'' in introductory provisions, was repealed by Pub. L. 111–152, § 1101(a)(2). See Construction of 2010 Amendment note below.

Subsec. (b)(4)(B)(i)(II) to (VI). Pub. L. 111–152, § 1101(d)(1), added subcls. (II) to (V) and redesignated former subcl. (II) as (VI).

Subsec. (b)(4)(C). Pub. L. 111–148, § 3314(a), in cl. (ii), substituted ''subject to clause (iii), such costs shall be treated as incurred only if'' for ''such costs shall be treated as incurred only if'' and struck out '', under section 1395w–114 of this title, or under a State Pharmaceutical Assistance Program'' after ''on behalf of the individual),'', and added cl. (iii).

Pub. L. 111–148, § 3301(c)(1)(A), substituted ''Except as provided in subparagraph (E), in applying'' for ''In applying'' in introductory provisions.

Subsec. (b)(4)(E). Pub. L. 111–152, § 1101(b)(3)(E), inserted before period at end '', except that incurred costs shall not include the portion of the negotiated price that represents the reduction in coinsurance resulting from the application of paragraph (2)(D)''.

Pub. L. 111–148, § 3301(c)(1)(B), added subpar. (E).

Subsec. (b)(7). Pub. L. 111–152, § 1101(d)(2), added par. (7).

Pub. L. 111–148, § 3315(2), which directed addition of par. (7), was repealed by Pub. L. 111–152, § 1101(a)(2). As enacted, text read as follows:

''(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

''(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

''(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

''(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

''(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.''

See Construction of 2010 Amendment note below.

2008—Subsec. (e)(1). Pub. L. 110–275, §182(a)(1)(A), substituted ''(as defined in paragraph (4))'' for ''(as defined in section 1396r–8(k)(6) of this title)'' in concluding provisions.

Subsec. (e)(2)(A). Pub. L. 110–275, §175(a), inserted ''other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines),'' after ''agents),''.

Subsec. (e)(4). Pub. L. 110–275, §182(a)(1)(B), which directed amendment of subsec. (e)(1) in the matter following subpar. (B) by adding par. (4) at the end, was executed by adding par. (4) at end of subsec. (e), to reflect the probable intent of Congress.

2006—Subsec. (e)(1). Pub. L. 109–432 inserted ''(and, for vaccines administered on or after January 1, 2008, its administration)'' after ''section 262 of this title'' in concluding provisions.

2005—Subsec. (e)(2)(A). Pub. L. 109–91, §103(a)(2), inserted at end ''Such term also does not include a drug when used for the treatment of sexual or erectile dysfunction, unless such drug were used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration.''

Pub. L. 109–91, §103(a)(1), inserted before period at end '', as such sections were in effect on December 8, 2003''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3301(c)(2), Mar. 23, 2010, 124 Stat. 468, provided that: ''The amendments made by this subsection [amending this section] shall apply to costs incurred on or after July 1, 2010.''

Pub. L. 111–148, title III, §3314(b), Mar. 23, 2010, 124 Stat. 479, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to costs incurred on or after January 1, 2011.''

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §175(b), July 15, 2008, 122 Stat. 2581, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to prescriptions dispensed on or after January 1, 2013.''

Pub. L. 110–275, title I, §182(a)(2), July 15, 2008, 122 Stat. 2583, provided that: ''The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2009.''

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, §103(c), Oct. 20, 2005, 119 Stat. 2092, provided that: ''The amendment made by subsection (a)(1) [amending this section] shall take effect as if included in the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) and the amendment made by subsection (a)(2) [amending this section] shall apply to coverage for drugs dispensed on or after January 1, 2007.''

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1101(a)(2), Mar. 30, 2010, 124 Stat. 1037, provided that: ''Section 3315 of the Patient Protection and Affordable Care Act [section 3315 of Pub. L. 111–148, amending this section] (including the amendments made by such section) is repealed, and any provision of law amended or repealed by such sections [sic] is hereby restored or revived as if such section had not been enacted into law.''

CONSTRUCTION

Pub. L. 109–91, title I, §103(b), Oct. 20, 2005, 119 Stat. 2092, provided that: ''Nothing in this section [amending this section and enacting provisions set out as a note under this section] shall be construed as preventing a prescription drug plan or an MA–PD plan from providing coverage of drugs for the treatment of sexual or erectile dysfunction as supplemental prescription drug coverage under section 1860D–2(a)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–102(a)(2)(A)(ii)).''

PAYMENT FOR ADMINISTRATION OF PART D VACCINES IN 2007

Pub. L. 109–432, div. B, title II, §202(a), Dec. 20, 2006, 120 Stat. 2986, provided that: ''Notwithstanding any other provision of law, in the case of a vaccine that is a covered part D drug under section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)) and that is administered during 2007, the administration of such vaccine shall be paid under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] as if it were the administration of a vaccine described in section 1861(s)(10)(B) of such Act (42 U.S.C. 1395w(s)(10)(B) [probably should be 1395x(s)(10)(B)]).''

§ 1395w–103. Access to a choice of qualified prescription drug coverage

(a) Assuring access to a choice of coverage

(1) Choice of at least two plans in each area

The Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan. In any such case in which such plans are not available, the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

(2) Requirement for different plan sponsors

The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

(3) Qualifying plan defined

For purposes of this section, the term ''qualifying plan'' means—

(A) a prescription drug plan; or

(B) an MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title that provides—

(i) basic prescription drug coverage; or

(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1395w–24(b)(1)(C) of this title.

(b) Flexibility in risk assumed and application of fallback plan

In order to ensure access pursuant to subsection (a) in an area—

(1) the Secretary may approve limited risk plans under section 1395w–111(f) of this title for the area; and

(2) only if such access is still not provided in the area after applying paragraph (1), the Secretary shall provide for the offering of a fallback prescription drug plan for that area under section 1395w–111(g) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–3, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2081.)

§ 1395w–104. Beneficiary protections for qualified prescription drug coverage

(a) Dissemination of information

(1) General information

(A) Application of MA information

A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1395w–22(c)(1) of this title relating to such plan, insofar as the Secretary determines appropriate with respect to benefits provided under this part, and, subject to subparagraph (C), including the information described in subparagraph (B).

(B) Drug specific information

The information described in this subparagraph is information concerning the following:

(i) Access to specific covered part D drugs, including access through pharmacy networks.

(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with paragraph (3).

(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with paragraph (3).

(iv) The medication therapy management program required under subsection (c).

(v) The drug management program for at-risk beneficiaries under subsection (c)(5).

(vi) For plan year 2021 and each subsequent plan year, subject to subparagraph (C), with respect to the treatment of pain—

(I) the risks associated with prolonged opioid use; and

(II) coverage of nonpharmacological therapies, devices, and nonopioid medications—

(aa) in the case of an MA–PD plan under part C, under such plan; and

(bb) in the case of a prescription drug plan, under such plan and under parts A and B.

(C) Targeted provision of information

A PDP sponsor of a prescription drug plan may, in lieu of disclosing the information described in subparagraph (B)(vi) to each enrollee under the plan, disclose such information through mail or electronic communications to a subset of enrollees under the plan, such as enrollees who have been prescribed an opioid in the previous 2-year period.

(2) Disclosure upon request of general coverage, utilization, and grievance information

Upon request of a part D eligible individual who is eligible to enroll in a prescription drug plan, the PDP sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in subparagraphs (A), (B), and (C) of section 1395w–22(c)(2) of this title to such individual.

(3) Provision of specific information

(A) Response to beneficiary questions

Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

(B) Availability of information on changes in formulary through the Internet

A PDP sponsor offering a prescription drug plan shall make available on a timely basis through an Internet website information on specific changes in the formulary under the plan (including changes to tiered or preferred status of covered part D drugs).

(4) Claims information

A PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees—

(A) an explanation of benefits (in accordance with section 1395b–7(a) of this title or in a comparable manner); and

(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to—

(i) the initial coverage limit for the current year; and

(ii) the annual out-of-pocket threshold for the current year.

Notices under subparagraph (B) need not be provided more often than as specified by the Secretary and notices under subparagraph (B)(ii) shall take into account the application of section 1395w–102(b)(4)(C) of this title to the extent practicable, as specified by the Secretary.

(b) Access to covered part D drugs

(1) Assuring pharmacy access

(A) Participation of any willing pharmacy

A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan.

(B) Discounts allowed for network pharmacies

For covered part D drugs dispensed through in-network pharmacies, a prescription drug plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for part D eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1395w–115 of this title to a plan.

(C) Convenient access for network pharmacies

(i) In general

The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules established by the Secretary).

(ii) Application of TRICARE standards

The Secretary shall establish rules for convenient access to in-network pharmacies under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(iii) Adequate emergency access

Such rules shall include adequate emergency access for enrollees.

(iv) Convenient access in long-term care facilities

Such rules may include standards with respect to access for enrollees who are residing in long-term care facilities and for pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 1603 of title 25).

(D) Level playing field

Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a pharmacy (other than a mail order pharmacy), with any differential in charge paid by such enrollees.

(E) Not required to accept insurance risk

The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

(2) Use of standardized technology

(A) In general

The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1395w–102(d) of this title.

(B) Standards

(i) In general

The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of subchapter XI and may be based on standards developed by an appropriate standard setting organization.

(ii) Consultation

In developing the standards under clause (i), the Secretary shall consult with the National Council for Prescription Drug Programs and other standard setting organizations determined appropriate by the Secretary.

(iii) Implementation

The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that PDP sponsors utilize such standards beginning January 1, 2006.

(3) Requirements on development and application of formularies

If a PDP sponsor of a prescription drug plan uses a formulary (including the use of tiered cost-sharing), the following requirements must be met:

(A) Development and revision by a pharmacy and therapeutic (P&T) committee

(i) In general

The formulary must be developed and reviewed by a pharmacy and therapeutic committee. A majority of the members of such committee shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

(ii) Inclusion of independent experts

Such committee shall include at least one practicing physician and at least one practicing pharmacist, each of whom—

(I) is independent and free of conflict with respect to the sponsor and plan; and

(II) has expertise in the care of elderly or disabled persons.

(B) Formulary development

In developing and reviewing the formulary, the committee shall—

(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

(ii) take into account whether including in the formulary (or in a tier in such formulary) particular covered part D drugs has therapeutic advantages in terms of safety and efficacy.

(C) Inclusion of drugs in all therapeutic categories and classes

(i) In general

Subject to subparagraph (G), the formulary must include drugs within each therapeutic category and class of covered part D drugs, although not necessarily all drugs within such categories and classes.

(ii) Model guidelines

The Secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

(iii) Limitation on changes in therapeutic classification

The PDP sponsor of a prescription drug plan may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs.

(D) Provider and patient education

The PDP sponsor shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

(E) Notice before removing drug from formulary or changing preferred or tier status of drug

Any removal of a covered part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available (such as under subsection (a)(3)) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

(F) Periodic evaluation of protocols

In connection with the formulary, the sponsor of a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

(G) Required inclusion of drugs in certain categories and classes

(i) Formulary requirements

(I) In general

Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

(II) Exceptions

The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

(ii) Identification of drugs in certain categories and classes

(I) In general

Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

(II) Criteria

The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

(iii) Implementation

The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

(iv) Requirement for certain categories and classes until criteria established

Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

(I) Anticonvulsants.
(II) Antidepressants.
(III) Antineoplastics.
(IV) Antipsychotics.
(V) Antiretrovirals.
(VI) Immunosuppressants for the treatment of transplant rejection.

(H) Use of single, uniform exceptions and appeals process

Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.

(4) Ensuring access during COVID–19 public health emergency period

(A) In general

During the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), a prescription drug plan or MA–PD plan shall, notwithstanding any cost and utilization management, medication therapy management, or other such programs under this part, permit a part D eligible individual enrolled in such plan to obtain in a single fill or refill, at the option of such individual, the total day supply (not to exceed a 90-day supply) prescribed for such individual for a covered part D drug.

(B) Safety edit exception

A prescription drug plan or MA–PD plan may not permit a part D eligible individual to obtain a single fill or refill inconsistent with an applicable safety edit.

(c) Cost and utilization management; quality assurance; medication therapy management program

(1) In general

The PDP sponsor shall have in place, directly or through appropriate arrangements, with respect to covered part D drugs, the following:

(A) A cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs (as defined in section 1396r–8(k)(7)(A)(i) of this title).

(B) Quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.

(C) A medication therapy management program described in paragraph (2).

(D) A program to control fraud, abuse, and waste.

(E) A utilization management tool to prevent drug abuse (as described in paragraph (6)(A)).[1]

(F) With respect to plan years beginning on or after January 1, 2022, a drug management program for at-risk beneficiaries described in paragraph (5).

Nothing in this section shall be construed as impairing a PDP sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

(2) Medication therapy management program

(A) Description

(i) In general

A medication therapy management program described in this paragraph is a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries described in clause (ii), that covered part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Such a program may distinguish between services in ambulatory and institutional settings.

(ii) Targeted beneficiaries described

Targeted beneficiaries described in this clause are the following:

(I) Part D eligible individuals who—

(aa) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure);

(bb) are taking multiple covered part D drugs; and

(cc) are identified as likely to incur annual costs for covered part D drugs that exceed a level specified by the Secretary.

(II) Beginning January 1, 2021, at-risk beneficiaries for prescription drug abuse (as defined in paragraph (5)(C)).

(B) Elements

Such program—

(i) may include elements that promote—

(I) enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, and other appropriate means;

(II) increased enrollee adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

(III) detection of adverse drug events and patterns of overuse and underuse of prescription drugs; and

(ii) with respect to plan years beginning on or after January 1, 2021, shall provide for—

(I) the provision of information to the enrollee on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under section 1395w–22(n)(2) of this title, including information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal; and

(II) cost-effective means by which an enrollee may so safely dispose of such drugs.

(C) Required interventions

For plan years beginning on or after the date that is 2 years after March 23, 2010, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

(i) An annual comprehensive medication review furnished person-to-person or using

[1] So in original. Probably means first par. (6).

telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

(I) shall include a review of the individual's medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

(D) Assessment

The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

(E)[2] Automatic enrollment with ability to opt-out

The prescription drug plan sponsor shall have in place a process to—

(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

(ii) permit such beneficiaries to opt-out of enrollment in such program.

(E)[2] Development of program in cooperation with licensed pharmacists

Such program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

(F) Coordination with care management plans

The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1395b–8 of this title.

(G) Considerations in pharmacy fees

The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1396r–8(b)(3)(D) of this title apply to information disclosed under this subparagraph.

(3) Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities

The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.

(4) Requiring valid prescriber National Provider Identifiers on pharmacy claims

(A) In general

For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

(B) Procedures

(i) Validity of prescriber National Provider Identifiers

The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

(ii) Informing beneficiaries of reason for denial

The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagraph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.

(C) Report

Not later than January 1, 2018, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).

[2] So in original. Two subpars. (E) have been enacted.

(D) Notification and additional requirements with respect to outlier prescribers of opioids

(i) Notification

Not later than January 1, 2021, the Secretary shall, in the case of a prescriber identified by the Secretary under clause (ii) to be an outlier prescriber of opioids, provide, subject to clause (iv), an annual notification to such prescriber that such prescriber has been so identified and that includes resources on proper prescribing methods and other information as specified in accordance with clause (iii).

(ii) Identification of outlier prescribers of opioids

(I) In general

The Secretary shall, subject to subclause (III), using the valid prescriber National Provider Identifiers included pursuant to subparagraph (A) on claims for covered part D drugs for part D eligible individuals enrolled in prescription drug plans under this part or MA–PD plans under part C and based on the thresholds established under subclause (II), identify prescribers that are outlier opioids prescribers for a period of time specified by the Secretary.

(II) Establishment of thresholds

For purposes of subclause (I) and subject to subclause (III), the Secretary shall, after consultation with stakeholders, establish thresholds, based on prescriber specialty and geographic area, for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers of opioids within such specialty and area.

(III) Exclusions

The following shall not be included in the analysis for identifying outlier prescribers of opioids under this clause:

(aa) Claims for covered part D drugs for part D eligible individuals who are receiving hospice care under this subchapter.

(bb) Claims for covered part D drugs for part D eligible individuals who are receiving oncology services under this subchapter.

(cc) Prescribers who are the subject of an investigation by the Centers for Medicare & Medicaid Services or the Inspector General of the Department of Health and Human Services.

(iii) Contents of notification

The Secretary shall include the following information in the notifications provided under clause (i):

(I) Information on how such prescriber compares to other prescribers within the same specialty and geographic area.

(II) Information on opioid prescribing guidelines, based on input from stakeholders, that may include the Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain and guidelines developed by physician organizations.

(III) Other information determined appropriate by the Secretary.

(iv) Modifications and expansions

(I) Frequency

Beginning 5 years after October 24, 2018, the Secretary may change the frequency of the notifications described in clause (i) based on stakeholder input and changes in opioid prescribing utilization and trends.

(II) Expansion to other prescriptions

The Secretary may expand notifications under this subparagraph to include identifications and notifications with respect to concurrent prescriptions of covered Part D drugs used in combination with opioids that are considered to have adverse side effects when so used in such combination, as determined by the Secretary.

(v) Additional requirements for persistent outlier prescribers

In the case of a prescriber who the Secretary determines is persistently identified under clause (ii) as an outlier prescriber of opioids, the following shall apply:

(I) Such prescriber may be required to enroll in the program under this subchapter under section 1395cc(j) of this title if such prescriber is not otherwise required to enroll, but only after other appropriate remedies have been provided, such as the provision of education funded through section 6052 of the SUPPORT for Patients and Communities Act, for a period determined by the Secretary as sufficient to correct the prescribing patterns that lead to identification of such prescriber as a persistent outlier prescriber of opioids. The Secretary shall determine the length of the period for which such prescriber is required to maintain such enrollment, which shall be the minimum period necessary to correct such prescribing patterns.

(II) Not less frequently than annually (and in a form and manner determined appropriate by the Secretary), the Secretary, consistent with clause(iv)(I), shall communicate information on such prescribers to sponsors of a prescription drug plan and Medicare Advantage organizations offering an MA–PD plan.

(vi) Public availability of information

The Secretary shall make aggregate information under this subparagraph available on the internet website of the Centers for Medicare & Medicaid Services. Such information shall be in a form and manner determined appropriate by the Secretary and shall not identify any specific prescriber. In carrying out this clause, the

Secretary shall consult with interested stakeholders.

(vii) Opioids defined

For purposes of this subparagraph, the term ''opioids'' has such meaning as specified by the Secretary.

(viii) Other activities

Nothing in this subparagraph shall preclude the Secretary from conducting activities that provide prescribers with information as to how they compare to other prescribers that are in addition to the activities under this subparagraph, including activities that were being conducted as October 24, 2018.

(5) Drug management program for at-risk beneficiaries

(A) Authority to establish

A PDP sponsor may (and for plan years beginning on or after January 1, 2022, a PDP sponsor shall) establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary's access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by one or more prescribers selected under subparagraph (D), and dispensed for such beneficiary by one or more pharmacies selected under such subparagraph.

(B) Requirement for notices

(i) In general

A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse.

(ii) Initial notice

An initial notice described in this clause is a notice that provides to the beneficiary—

(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

(II) information describing all State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary has access, including mental health services and other counseling services;

(III) notice of, and information about, the right of the beneficiary to appeal such identification under subsection (h), including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution;

(IV) a request for the beneficiary to submit to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

(V) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

(VI) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor; and

(VII) contact information for other organizations that can provide the beneficiary with assistance regarding such drug management program (similar to the information provided by the Secretary in other standardized notices provided to part D eligible individuals enrolled in prescription drug plans under this part).

(iii) Second notice

A second notice described in this clause is a notice that provides to the beneficiary notice—

(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

(II) that such beneficiary is subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

(III) of the prescriber (or prescribers) and pharmacy (or pharmacies) selected for such individual under subparagraph (D);

(IV) of, and information about, the beneficiary's right to appeal such identification under subsection (h), including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution;

(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subpara-

graph (D), submit such preferences to the PDP sponsor; and

(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor.

(iv) Timing of notices

(I) In general

Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 30 days after an initial notice described in clause (ii) is provided to the beneficiary.

(II) Exception

In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rulemaking by the Secretary regarding the health or safety of the beneficiary or regarding significant drug diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (I), the PDP sponsor may provide such second notice on such earlier date.

(C) At-risk beneficiary for prescription drug abuse

(i) In general

Except as provided in clause (v), for purposes of this paragraph, the term ''at-risk beneficiary for prescription drug abuse'' means a part D eligible individual who is not an exempted individual described in clause (ii) and—

(I) who is identified as such an at-risk beneficiary through the use of clinical guidelines that indicate misuse or abuse of prescription drugs described in subparagraph (G) and that are developed by the Secretary in consultation with PDP sponsors and other stakeholders, including individuals entitled to benefits under part A or enrolled under part B, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers; or

(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under the prescription drug plan in which such individual was most recently previously enrolled and such identification has not been terminated under subparagraph (F).

(ii) Exempted individual described

An exempted individual described in this clause is an individual who—

(I) receives hospice care under this subchapter;

(II) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(III) the Secretary elects to treat as an exempted individual for purposes of clause (i).

(iii) Program size

The Secretary shall establish policies, including the guidelines developed under clause (i)(I) and the exemptions under clause (ii)(III), to ensure that the population of enrollees in a drug management program for at-risk beneficiaries operated by a prescription drug plan can be effectively managed by such plans.

(iv) Clinical contact

With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by a PDP sponsor, the PDP sponsor shall contact the beneficiary's providers who have prescribed frequently abused drugs regarding whether prescribed medications are appropriate for such beneficiary's medical conditions.

(v) Treatment of enrollees with a history of opioid-related overdose

(I) In general

For plan years beginning not later than January 1, 2021, a part D eligible individual who is not an exempted individual described in clause (ii) and who is identified under this clause as a part D eligible individual with a history of opioid-related overdose (as defined by the Secretary) shall be included as a potentially at-risk beneficiary for prescription drug abuse under the drug management program under this paragraph.

(II) Identification and notice

For purposes of this clause, the Secretary shall—

(aa) identify part D eligible individuals with a history of opioid-related overdose (as so defined); and

(bb) notify the PDP sponsor of the prescription drug plan in which such an individual is enrolled of such identification.

(D) Selection of prescribers and pharmacies

(i) In general

With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(IV) and (iii)(V) of subparagraph (B) (except as otherwise provided in this subparagraph) select—

(I) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, individual who is authorized to prescribe frequently abused drugs (referred to in this

paragraph as a ''prescriber'') who may write prescriptions for such drugs for such beneficiary; and

(II) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, pharmacy that may dispense such drugs to such beneficiary.

For purposes of subclause (II), in the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy.

(ii) Reasonable access

In making the selections under this subparagraph—

(I) a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to frequently abused drugs (as defined in subparagraph (G)), taking into account geographic location, beneficiary preference, impact on costsharing, and reasonable travel time; and

(II) a PDP sponsor shall ensure such access (including access to prescribers and pharmacies with respect to frequently abused drugs) in the case of individuals with multiple residences, in the case of natural disasters and similar situations, and in the case of the provision of emergency services.

(iii) Beneficiary preferences

If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

(I) review such preferences;

(II) select or change the selection of prescribers and pharmacies for the beneficiary based on such preferences; and

(III) inform the beneficiary of such selection or change of selection.

(iv) Exception regarding beneficiary preferences

In the case that the PDP sponsor determines that a change to the selection of prescriber or pharmacy under clause (iii)(II) by the PDP sponsor is contributing or would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in clause (iii). If the PDP sponsor changes the selection pursuant to the preceding sentence, the PDP sponsor shall provide the beneficiary with—

(I) at least 30 days written notice of the change of selection; and

(II) a rationale for the change.

(v) Confirmation

Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must notify the prescriber and pharmacy that the beneficiary involved has been identified for inclusion in the drug management program for at-risk beneficiaries and that the prescriber and pharmacy has been selected as the beneficiary's designated prescriber and pharmacy.

(E) Terminations and appeals

The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, the selection of prescriber or pharmacy under subparagraph (D), and information to be shared under subparagraph (I), with respect to such individual, shall be subject to reconsideration and appeal under subsection (h) and if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution.

(F) Termination of identification

(i) In general

The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such standards such identification shall terminate as of the earlier of—

(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); and

(II) the end of such maximum period of identification as the Secretary may specify.

(ii) Rule of construction

Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph (C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

(G) Frequently abused drug

For purposes of this subsection, the term ''frequently abused drug'' means a drug that is a controlled substance that the Secretary determines to be frequently abused or diverted.

(H) Data disclosure

(i) Data on decision to impose limitation

In the case of an at-risk beneficiary for prescription drug abuse (or an individual who is a potentially at-risk beneficiary for prescription drug abuse) whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, the Secretary shall establish rules and procedures to require the PDP sponsor to

disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part.

(ii) Data to reduce fraud, abuse, and waste

The Secretary shall establish rules and procedures to require PDP sponsors operating a drug management program for at-risk beneficiaries under this paragraph to provide the Secretary with such data as the Secretary determines appropriate for purposes of identifying patterns of prescription drug utilization for plan enrollees that are outside normal patterns and that may indicate fraudulent, medically unnecessary, or unsafe use.

(I) Sharing of information for subsequent plan enrollments

The Secretary shall establish procedures under which PDP sponsors who offer prescription drug plans shall share information with respect to individuals who are at-risk beneficiaries for prescription drug abuse (or individuals who are potentially at-risk beneficiaries for prescription drug abuse) and enrolled in a prescription drug plan and who subsequently disenroll from such plan and enroll in another prescription drug plan offered by another PDP sponsor.

(J) Privacy issues

Prior to the implementation of the rules and procedures under this paragraph, the Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subparagraphs (H) and (I) by PDP sponsors. Such clarification shall provide that the sharing of such data shall be considered to be protected health information in accordance with the requirements of the regulations promulgated pursuant to such section 264(c).

(K) Education

The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

(i) provided by Medicare administrative contractors through the improper payment outreach and education program described in section 1395kk–1(h) of this title; and

(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.

(L) Application under MA–PD plans

Pursuant to section 1395w–131(c)(1) of this title, the provisions of this paragraph apply under part D to MA organizations offering MA–PD plans to MA eligible individuals in the same manner as such provisions apply under this part to a PDP sponsor offering a prescription drug plan to a part D eligible individual.

(M) CMS compliance review

The Secretary shall ensure that existing plan sponsor compliance reviews and audit processes include the drug management programs for at-risk beneficiaries under this paragraph, including appeals processes under such programs.

(6)[3] Utilization management tool to prevent drug abuse

(A) In general

A tool described in this paragraph is any of the following:

(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

(ii) Retrospective utilization review to identify—

(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

(iii) Consultation with the contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

(B) Reporting

A PDP sponsor offering a prescription drug plan (and an MA organization offering an MA–PD plan) in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1395ddd of this title with respect to such State a report, on a monthly basis, containing information on—

(i) any provider of services or supplier described in subparagraph (A)(ii)(II) that is identified by such plan sponsor (or organization) during the 30-day period before such report is submitted; and

(ii) the name and prescription records of individuals described in paragraph (5)(C).

(C) CMS compliance review

The Secretary shall ensure that plan sponsor compliance reviews and program audits biennially include a certification that utilization management tools under this paragraph are in compliance with the requirements for such tools.

[3] So in original. Two pars. (6) have been enacted.

(6)[3] Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes

(A) Process

Subject to subparagraph (B), the Secretary shall establish a process under which a PDP sponsor of a prescription drug plan may submit a request for the Secretary to provide the sponsor, on a periodic basis and in an electronic format, beginning in plan year 2020, data described in subparagraph (D) with respect to enrollees in such plan. Such data shall be provided without regard to whether such enrollees are described in clause (ii) of paragraph (2)(A).

(B) Purposes

A PDP sponsor may use the data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

(i) To optimize therapeutic outcomes through improved medication use, as such phrase is used in clause (i) of paragraph (2)(A).

(ii) To improving care coordination so as to prevent adverse health outcomes, such as preventable emergency department visits and hospital readmissions.

(iii) For any other purpose determined appropriate by the Secretary.

(C) Limitations on data use

A PDP sponsor shall not use data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

(i) To inform coverage determinations under this part.

(ii) To conduct retroactive reviews of medically accepted indications determinations.

(iii) To facilitate enrollment changes to a different prescription drug plan or an MA–PD plan offered by the same parent organization.

(iv) To inform marketing of benefits.

(v) For any other purpose that the Secretary determines is necessary to include in order to protect the identity of individuals entitled to, or enrolled for, benefits under this subchapter and to protect the security of personal health information.

(D) Data described

The data described in this clause are standardized extracts (as determined by the Secretary) of claims data under parts A and B for items and services furnished under such parts for time periods specified by the Secretary. Such data shall include data as current as practicable.

(d) Consumer satisfaction surveys

In order to provide for comparative information under section 1395w–101(c)(3)(A)(v) of this title, the Secretary shall conduct consumer satisfaction surveys with respect to PDP sponsors and prescription drug plans in a manner similar to the manner such surveys are conducted for MA organizations and MA plans under part C.

(e) Electronic prescription program

(1) Application of standards

As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

(2) Program requirements

Consistent with uniform standards established under paragraph (3)—

(A) Provision of information to prescribing health care professional and dispensing pharmacies and pharmacists

An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

(B) Application to medical history information

Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

(C) Limitations

Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(D) Timing

To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.

(E) Electronic prior authorization

(i) In general

Not later than January 1, 2021, the program shall provide for the secure electronic transmission of—

(I) a prior authorization request from the prescribing health care professional for coverage of a covered part D drug for a part D eligible individual enrolled in a part D plan (as defined in section 1395w–133(a)(5) of this title) to the PDP sponsor or Medicare Advantage organization offering such plan; and

(II) a response, in accordance with this subparagraph, from such PDP sponsor or Medicare Advantage organization, respectively, to such professional.

(ii) Electronic transmission

(I) Exclusions

For purposes of this subparagraph, a facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission described in clause (i).

(II) Standards

In order to be treated, for purposes of this subparagraph, as an electronic transmission described in clause (i), such transmission shall comply with technical standards adopted by the Secretary in consultation with the National Council for Prescription Drug Programs, other standard setting organizations determined appropriate by the Secretary, and stakeholders including PDP sponsors, Medicare Advantage organizations, health care professionals, and health information technology software vendors.

(III) Application

Notwithstanding any other provision of law, for purposes of this subparagraph, the Secretary may require the use of such standards adopted under subclause (II) in lieu of any other applicable standards for an electronic transmission described in clause (i) for a covered part D drug for a part D eligible individual.

(3) Standards

(A) In general

The Secretary shall provide consistent with this subsection for the promulgation of uniform standards relating to the requirements for electronic prescription drug programs under paragraph (2).

(B) Objectives

Such standards shall be consistent with the objectives of improving—

(i) patient safety;

(ii) the quality of care provided to patients; and

(iii) efficiencies, including cost savings, in the delivery of care.

(C) Design criteria

Such standards shall—

(i) be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on prescribing health care professionals and dispensing pharmacies and pharmacists;

(ii) be compatible with standards established under part C of subchapter XI, standards established under subsection (b)(2)(B)(i), and with general health information technology standards; and

(iii) be designed so that they permit electronic exchange of drug labeling and drug listing information maintained by the Food and Drug Administration and the National Library of Medicine.

(D) Permitting use of appropriate messaging

Such standards shall allow for the messaging of information only if it relates to the appropriate prescribing of drugs, including quality assurance measures and systems referred to in subsection (c)(1)(B).

(E) Permitting patient designation of dispensing pharmacy

(i) In general

Consistent with clause (ii), such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

(ii) No change in benefits

Clause (i) shall not be construed as affecting—

(I) the access required to be provided to pharmacies by a prescription drug plan; or

(II) the application of any differences in benefits or payments under such a plan based on the pharmacy dispensing a covered part D drug.

(4) Development, promulgation, and modification of standards

(A) Initial standards

Not later than September 1, 2005, the Secretary shall develop, adopt, recognize, or modify initial uniform standards relating to the requirements for electronic prescription drug programs described in paragraph (2) taking into consideration the recommendations (if any) from the National Committee on Vital and Health Statistics (as established under section 242k(k) of this title) under subparagraph (B).

(B) Role of NCVHS

The National Committee on Vital and Health Statistics shall develop recommendations for uniform standards relating to such requirements in consultation with the following:

(i) Standard setting organizations (as defined in section 1320d(8) of this title)[4]

(ii) Practicing physicians.

(iii) Hospitals.

(iv) Pharmacies.

(v) Practicing pharmacists.

(vi) Pharmacy benefit managers.

(vii) State boards of pharmacy.

(viii) State boards of medicine.

(ix) Experts on electronic prescribing.

[4] So in original. Probably should be followed by a period.

(x) Other appropriate Federal agencies.

(C) Pilot project to test initial standards

(i) In general

During the 1-year period that begins on January 1, 2006, the Secretary shall conduct a pilot project to test the initial standards developed under subparagraph (A) prior to the promulgation of the final uniform standards under subparagraph (D) in order to provide for the efficient implementation of the requirements described in paragraph (2).

(ii) Exception

Pilot testing of standards is not required under clause (i) where there already is adequate industry experience with such standards, as determined by the Secretary after consultation with effected standard setting organizations and industry users.

(iii) Voluntary participation of physicians and pharmacies

In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, MA organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

(iv) Evaluation and report

(I) Evaluation

The Secretary shall conduct an evaluation of the pilot project conducted under clause (i).

(II) Report to Congress

Not later than April 1, 2007, the Secretary shall submit to Congress a report on the evaluation conducted under subclause (I).

(D) Final standards

Based upon the evaluation of the pilot project under subparagraph (C)(iv)(I) and not later than April 1, 2008, the Secretary shall promulgate uniform standards relating to the requirements described in paragraph (2).

(5) Relation to State laws

The standards promulgated under this subsection shall supersede any State law or regulation that—

(A) is contrary to the standards or restricts the ability to carry out this part; and

(B) pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered part D drugs under this part.

(6) Establishment of safe harbor

The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1320a–7b(b) of this title and an exception to the prohibition under subsection (a)(1) of section 1395nn of this title with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

(A) in the case of a hospital, by the hospital to members of its medical staff;

(B) in the case of a group practice (as defined in section 1395nn(h)(4) of this title), by the practice to prescribing health care professionals who are members of such practice; and

(C) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

(7) Requirement of e-prescribing for controlled substances

(A) In general

Subject to subparagraph (B), a prescription for a covered part D drug under a prescription drug plan (or under an MA–PD plan) for a schedule II, III, IV, or V controlled substance shall be transmitted by a health care practitioner electronically in accordance with an electronic prescription drug program that meets the requirements of paragraph (2).

(B) Exception for certain circumstances

The Secretary shall, through rulemaking, specify circumstances and processes by which the Secretary may waive the requirement under subparagraph (A), with respect to a covered part D drug, including in the case of—

(i) a prescription issued when the practitioner and dispensing pharmacy are the same entity;

(ii) a prescription issued that cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;

(iii) a prescription issued by a practitioner who received a waiver or a renewal thereof for a period of time as determined by the Secretary, not to exceed one year, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner;

(iv) a prescription issued by a practitioner under circumstances in which, notwithstanding the practitioner's ability to submit a prescription electronically as required by this subsection, such practitioner reasonably determines that it would be impractical for the individual involved to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition involved;

(v) a prescription issued by a practitioner prescribing a drug under a research protocol;

(vi) a prescription issued by a practitioner for a drug for which the Food and Drug Administration requires a prescription to contain elements that are not able to be included in electronic prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;

(vii) a prescription issued by a practitioner—

(I) for an individual who receives hospice care under this subchapter; and

(II) that is not covered under the hospice benefit under this subchapter; and

(viii) a prescription issued by a practitioner for an individual who is—

(I) a resident of a nursing facility (as defined in section 1396r(a) of this title); and

(II) dually eligible for benefits under this subchapter and subchapter XIX.

(C) Dispensing

(i) Nothing in this paragraph shall be construed as requiring a sponsor of a prescription drug plan under this part, MA organization offering an MA–PD plan under part C, or a pharmacist to verify that a practitioner, with respect to a prescription for a covered part D drug, has a waiver (or is otherwise exempt) under subparagraph (B) from the requirement under subparagraph (A).

(ii) Nothing in this paragraph shall be construed as affecting the ability of the plan to cover or the pharmacists' ability to continue to dispense covered part D drugs from otherwise valid written, oral, or fax prescriptions that are consistent with laws and regulations.

(iii) Nothing in this paragraph shall be construed as affecting the ability of an individual who is being prescribed a covered part D drug to designate a particular pharmacy to dispense the covered part D drug to the extent consistent with the requirements under subsection (b)(1) and under this paragraph.

(D) Enforcement

The Secretary shall, through rulemaking, have authority to enforce and specify appropriate penalties for non-compliance with the requirement under subparagraph (A).

(f) Grievance mechanism

Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1395w–22(f) of this title.

(g) Coverage determinations and reconsiderations

(1) Application of coverage determination and reconsideration provisions

A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1395w–22(g) of this title with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an MA organization with respect to benefits it offers under an MA plan under part C.

(2) Request for a determination for the treatment of tiered formulary drug

In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, a part D eligible individual who is enrolled in the plan may request an exception to the tiered cost-sharing structure. Under such an exception, a nonpreferred drug could be covered under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both. A PDP sponsor shall have an exceptions process under this paragraph consistent with guidelines established by the Secretary for making a determination with respect to such a request. Denial of such an exception shall be treated as a coverage denial for purposes of applying subsection (h).

(h) Appeals

(1) In general

Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1395w–22(g) of this title with respect to benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an MA organization with respect to benefits under the original medicare fee-for-service program option it offers under an MA plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

(2) Limitation in cases on nonformulary determinations

A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination not to provide for coverage of a covered part D drug that is not on the formulary under the plan only if the prescribing physician determines that all covered part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.

(3) Treatment of nonformulary determinations

If a PDP sponsor determines that a plan provides coverage for a covered part D drug that is not on the formulary of the plan, the drug shall be treated as being included on the formulary for purposes of section 1395w–102(b)(4)(C)(i) of this title.

(i) Privacy, confidentiality, and accuracy of enrollee records

The provisions of section 1395w–22(h) of this title shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an MA organization and an MA plan.

(j) Treatment of accreditation

Subparagraph (A) of section 1395w–22(e)(4) of this title (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an MA organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

(1) Subsection (b) of this section (relating to access to covered part D drugs).

(2) Subsection (c) of this section (including quality assurance and medication therapy management).

(3) Subsection (i) of this section (relating to confidentiality and accuracy of enrollee records).

(k) Public disclosure of pharmaceutical prices for equivalent drugs

(1) In general

A PDP sponsor offering a prescription drug plan shall provide that each pharmacy that dispenses a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(2) Timing of notice

(A) In general

Subject to subparagraph (B), the information under paragraph (1) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(B) Waiver

The Secretary may waive subparagraph (A) in such circumstances as the Secretary may specify.

***(l)* Requirements with respect to sales and marketing activities**

The following provisions shall apply to a PDP sponsor (and the agents, brokers, and other third parties representing such sponsor) in the same manner as such provisions apply to a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization):

(1) The prohibition under section 1395w–21(h)(4)(C) of this title on conducting activities described in section 1395w–21(j)(1) of this title.

(2) The requirement under section 1395w–21(h)(4)(D) of this title to conduct activities described in section 1395w–21(j)(2) of this title in accordance with the limitations established under such subsection.

(3) The inclusion of the plan type in the plan name under section 1395w–21(h)(6) of this title.

(4) The requirements regarding the appointment of agents and brokers and compliance with State information requests under subparagraphs (A) and (B), respectively, of section 1395w–21(h)(7) of this title.

(m) Prohibition on limiting certain information on drug prices

A PDP sponsor and a Medicare Advantage organization shall ensure that each prescription drug plan or MA–PD plan offered by the sponsor or organization does not restrict a pharmacy that dispenses a prescription drug or biological from informing, nor penalize such pharmacy for informing, an enrollee in such plan of any differential between the negotiated price of, or copayment or coinsurance for, the drug or biological to the enrollee under the plan and a lower price the individual would pay for the drug or biological if the enrollee obtained the drug without using any health insurance coverage.

(n) Program integrity transparency measures

For program integrity transparency measures applied with respect to prescription drug plan and MA plans, see section 1395w–28(i) of this title.

***(o)* Real-time benefit information**

(1) In general

After the Secretary has adopted a standard under paragraph (3) for electronic real-time benefit tools, and at a time determined appropriate by the Secretary, a PDP sponsor of a prescription drug plan shall implement one or more of such tools that meet the requirements described in paragraph (2).

(2) Requirements

For purposes of paragraph (1), the requirements described in this paragraph, with respect to an electronic real-time benefit tool, are that the tool is capable of—

(A) integrating with electronic prescribing and electronic health record systems of prescribing health care professionals for the transmission of formulary and benefit information in real time to such professionals; and

(B) with respect to a covered part D drug, transmitting such information specific to an individual enrolled in a prescription drug plan, including the following:

(i) A list of any clinically-appropriate alternatives to such drug included in the formulary of such plan.

(ii) Cost-sharing information and the negotiated price for such drug and such alternatives at multiple pharmacy options, including the individual's preferred pharmacy and, as applicable, other retail pharmacies and a mail order pharmacy.

(iii) The formulary status of such drug and such alternatives and any prior authorization or other utilization management requirements applicable to such drug and such alternatives included in the formulary of such plan.

(3) Standards

In order to be treated (for purposes of this subsection) as an electronic real-time benefit tool described in paragraph (1), such tool shall comply with technical standards adopted by

the Secretary in consultation with the National Coordinator for Health Information Technology through notice and comment rulemaking. Such technical standards adopted by the Secretary shall be developed by a standards development organization, such as the National Council for Prescription Drug Programs, that consults with stakeholders such as PDP sponsors, Medicare Advantage organizations, beneficiary advocates, health care professionals, and health information technology software vendors.

(4) Rules of construction

Nothing in this subsection shall be construed—

(A) to prohibit the application of paragraph (b)(7) of section 423.160 of title 42, Code of Federal Regulations, as is to be added to such section pursuant to the final rule published in the Federal Register on May 23, 2019, and titled ''Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses'' (84 Fed. Reg. 23832 through 23884); or

(B) to allow a PDP sponsor to use a real-time benefit tool to steer an individual, without the consent of the individual, to a particular pharmacy or pharmacy type over their preferred pharmacy or pharmacy type nor prohibit the designation of an individual's preferred pharmacy under such tool.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–4, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2082; amended Pub. L. 110–275, title I, §§103(a)(2), (b)(2), (c)(2), (d)(2), 176, July 15, 2008, 122 Stat. 2499–2501, 2581; Pub. L. 111–148, title III, §§3307(a), 3310(a), 3312(a), title X, §10328(a), Mar. 23, 2010, 124 Stat. 471, 475, 476, 964; Pub. L. 114–10, title V, §507, Apr. 16, 2015, 129 Stat. 168; Pub. L. 114–198, title VII, §704(a)(1), (2), (b), July 22, 2016, 130 Stat. 742–748; Pub. L. 115–123, div. E, title III, §50354, Feb. 9, 2018, 132 Stat. 213; Pub. L. 115–262, §2(a), Oct. 10, 2018, 132 Stat. 3670; Pub. L. 115–271, title II, §§2003(a), 2004, 2006, 2007(a), title VI, §§6062, 6063(c)–6065, 6102, 6103(b), Oct. 24, 2018, 132 Stat. 3926, 3928, 3930, 3986, 3989, 4004, 4005; Pub. L. 116–136, div. A, title III, §3714(a), Mar. 27, 2020, 134 Stat. 424; Pub. L. 116–260, div. CC, title I, §119(a), Dec. 27, 2020, 134 Stat. 2951.)

Editorial Notes

REFERENCES IN TEXT

Section 6052 of the SUPPORT for Patients and Communities Act, referred to in subsec. (c)(4)(D)(v)(I), is section 6052 of title VI of Pub. L. 115–271, which is set out as a note under this section.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsecs. (c)(5)(J) and (e)(2)(C), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

Section 119 of the Medicare Improvements for Patients and Providers Act of 2008, referred to in subsec. (c)(5)(K)(ii), is section 119 of Pub. L. 110–275, which is set out as a note under section 1395b–3 of this title.

AMENDMENTS

2020—Subsec. (b)(4). Pub. L. 116–136 added par. (4).

Subsecs. (m), (n). Pub. L. 116–260, §119(a)(1), redesignated subsec. (m), relating to program integrity transparency measures, as (n).

Subsec. (*o*). Pub. L. 116–260, §119(a)(2), added subsec. (*o*).

2018—Subsec. (a)(1)(A). Pub. L. 115–271, §6102(1), inserted '', subject to subparagraph (C),'' before ''including''.

Subsec. (a)(1)(B)(vi). Pub. L. 115–271, §6102(2), added cl. (vi).

Subsec. (a)(1)(C). Pub. L. 115–271, §6102(3), added subpar. (C).

Subsec. (c)(1)(F). Pub. L. 115–271, §2004(1), added subpar. (F).

Subsec. (c)(2)(A)(ii). Pub. L. 115–271, §6064, substituted ''are the following:'' for ''are part D eligible individuals who—'' in introductory provisions, added subcls. (I) and (II), redesignated former subcls. (I) to (III) as items (aa) to (cc), respectively, of subcl. (I), and realigned margins.

Subsec. (c)(2)(B). Pub. L. 115–271, §6103(b), struck out ''may include elements that promote'' after ''program'' in introductory provisions, added cls. (i) and (ii), redesignated former cls. (i) to (iii) as subcls. (I) to (III), respectively, of cl. (i), and realigned margins.

Subsec. (c)(4)(D). Pub. L. 115–271, §6065, added subpar. (D).

Subsec. (c)(5)(A). Pub. L. 115–271, §2004(2), inserted ''(and for plan years beginning on or after January 1, 2022, a PDP sponsor shall)'' after ''A PDP sponsor may''.

Subsec. (c)(5)(B)(ii)(III), (iii)(IV). Pub. L. 115–271, §2007(a)(1), substituted '', including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution'' for ''and the option of an automatic escalation to external review''.

Subsec. (c)(5)(C)(i). Pub. L. 115–271, §2006(1), substituted ''Except as provided in clause (v), for purposes'' for ''For purposes''.

Subsec. (c)(5)(C)(v). Pub. L. 115–271, §2006(2), added cl. (v).

Subsec. (c)(5)(E). Pub. L. 115–271, §2007(a)(2), substituted ''and if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution.'' for ''and the option of an automatic escalation to external review to the extent provided by the Secretary.''

Subsec. (c)(6). Pub. L. 115–123 added par. (6) relating to providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes.

Subsec. (e)(2)(E). Pub. L. 115–271, §6062, added subpar. (E).

Subsec. (e)(7). Pub. L. 115–271, §2003(a), added par. (7).

Subsec. (m). Pub. L. 115–271, §6063(c), added subsec. (m) relating to program integrity transparency measures.

Pub. L. 115–262 added subsec. (m) relating to prohibition on limiting certain information on drug prices.

2016—Subsec. (a)(1)(B)(v). Pub. L. 114–198, §704(a)(2), added cl. (v).

Subsec. (c)(1)(E). Pub. L. 114–198, §704(b)(1), added subpar. (E).

Subsec. (c)(5). Pub. L. 114–198, §704(a)(1), added par. (5).

Subsec. (c)(6). Pub. L. 114–198, §704(b)(2), added par. (6).

2015—Subsec. (c)(4). Pub. L. 114–10 added par. (4).

2010—Subsec. (b)(3)(G). Pub. L. 111–148, §3307(a), amended subpar. (G) generally. Prior to amendment, subpar. (G) related to required inclusion of drugs in certain categories and classes.

Subsec. (b)(3)(H). Pub. L. 111–148, §3312(a), added subpar. (H).

Subsec. (c)(2)(C) to (G). Pub. L. 111–148, §10328(a), added subpars. (C) to (E) and redesignated former subpars. (C) to(E) as (E) to (G), respectively.

Subsec. (c)(3). Pub. L. 111–148, §3310(a), added par. (3).

2008—Subsec. (b)(3)(C)(i). Pub. L. 110–275, §176(1), substituted ''Subject to subparagraph (G), the formulary'' for ''The formulary''.

Subsec. (b)(3)(G). Pub. L. 110–275, §176(2), added subpar. (G).

Subsec. (*l*). Pub. L. 110–275, §103(a)(2), added subsec. (*l*).

Subsec. (*l*)(2). Pub. L. 110–275, §103(b)(2), added par. (2).

Subsec. (*l*)(3). Pub. L. 110–275, §103(c)(2), added par. (3).

Subsec. (*l*)(4). Pub. L. 110–275, §103(d)(2), added par. (4).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2003(b), Oct. 24, 2018, 132 Stat. 3928, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to coverage of drugs prescribed on or after January 1, 2021.''

Pub. L. 115–271, title II, §2007(b), Oct. 24, 2018, 132 Stat. 3931, provided that: ''The amendments made by subsection (a) [amending this section] shall apply beginning not later [than] January 1, 2021.''

Pub. L. 115–262, §2(b), Oct. 10, 2018, 132 Stat. 3671, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2020.''

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3307(b), Mar. 23, 2010, 124 Stat. 472, provided that: ''The amendments made by this section [amending this section] shall apply to plan year 2011 and subsequent plan years.''

Pub. L. 111–148, title III, §3310(b), Mar. 23, 2010, 124 Stat. 475, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2012.''

Pub. L. 111–148, title III, §3312(b), Mar. 23, 2010, 124 Stat. 476, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to exceptions and appeals on or after January 1, 2012.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 103(a)(2) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 103(a)(3) of Pub. L. 110–275, set out as a note under section 1395w–21 of this title.

Amendment by section 103(b)(2) of Pub. L. 110–275 effective on a date specified by the Secretary (but in no case later than Nov. 15, 2008), see section 103(b)(3) of Pub. L. 110–275, set out as a note under section 1395w–21 of this title.

Amendment by section 103(d)(2) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 103(d)(3) of Pub. L. 110–275, set out as a note under section 1395w–21 of this title.

RULE OF CONSTRUCTION

Pub. L. 111–148, title X, §10328(b), Mar. 23, 2010, 124 Stat. 965, provided that: ''Nothing in this section [amending this section] shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act [42 U.S.C. 1315a], as added by section 3021 [of Pub. L. 111–148].''

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3714(b), Mar. 27, 2020, 134 Stat. 424, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by this section [amending this section] by program instruction or otherwise.''

UPDATE OF BIOMETRIC COMPONENT OF MULTIFACTOR AUTHENTICATION

Pub. L. 115–271, title II, §2003(c), Oct. 24, 2018, 132 Stat. 3928, provided that: ''Not later than 1 year after the date of enactment of this Act [Oct. 24, 2018], the Attorney General shall update the requirements for the biometric component of multifactor authentication with respect to electronic prescriptions of controlled substances.''

GRANTS TO PROVIDE TECHNICAL ASSISTANCE TO OUTLIER PRESCRIBERS OF OPIOIDS

Pub. L. 115–271, title VI, §6052, Oct. 24, 2018, 132 Stat. 3985, provided that:

''(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall, through the Centers for Medicare & Medicaid Services, award grants, contracts, or cooperative agreements to eligible entities for the purposes described in subsection (b).

''(b) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under subsection (a) shall be used to support eligible entities through technical assistance—

''(1) to educate and provide outreach to outlier prescribers of opioids about best practices for prescribing opioids;

''(2) to educate and provide outreach to outlier prescribers of opioids about non-opioid pain management therapies; and

''(3) to reduce the amount of opioid prescriptions prescribed by outlier prescribers of opioids.

''(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) an organization—

''(i) that has demonstrated experience providing technical assistance to health care professionals on a State or regional basis; and

''(ii) that has at least—

''(I) one individual who is a representative of consumers on its governing body; and

''(II) one individual who is a representative of health care providers on its governing body; or

''(B) an entity that is a quality improvement entity with a contract under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.).

''(2) OUTLIER PRESCRIBER OF OPIOIDS.—The term 'outlier prescriber of opioids' means, with respect to a period, a prescriber identified by the Secretary under subparagraph (D)(ii) of section 1860D–4(c)(4) of the Social Security Act (42 U.S.C. 1395w–104(c)(4)), as added by section 6065 of this Act, to be an outlier prescriber of opioids for such period.

''(3) PRESCRIBERS.—The term 'prescriber' means any health care professional, including a nurse practitioner or physician assistant, who is licensed to prescribe opioids by the State or territory in which such professional practices.

''(f) FUNDING.—For purposes of implementing this section, $75,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to remain available until expended.''

GRANTS TO PHYSICIANS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS

Pub. L. 108–173, title I, § 108, Dec. 8, 2003, 117 Stat. 2172, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] is authorized to make grants to physicians for the purpose of assisting such physicians to implement electronic prescription drug programs that comply with the standards promulgated or modified under section 1860D–4(e) of the Social Security Act [42 U.S.C. 1395w–104(e)], as inserted by section 101(a).

''(b) AWARDING OF GRANTS.—

''(1) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted and approved in a time, manner, and form specified by the Secretary.

''(2) CONSIDERATIONS AND PREFERENCES.—In awarding grants under this section, the Secretary shall—

''(A) give special consideration to physicians who serve a disproportionate number of medicare patients; and

''(B) give preference to physicians who serve a rural or underserved area.

''(3) LIMITATION ON GRANTS.—Only 1 grant may be awarded under this section with respect to any physician or group practice of physicians.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Grants under this section shall be made under such terms and conditions as the Secretary specifies consistent with this section.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this section may be used for any of the following:

''(A) For purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(C) Providing education and training to eligible physician staff on the use of technology to implement the electronic transmission of prescription and patient information.

''(3) PROVISION OF INFORMATION.—As a condition for the awarding of a grant under this section, an applicant shall provide to the Secretary such information as the Secretary may require in order to—

''(A) evaluate the project for which the grant is made; and

''(B) ensure that funding provided under the grant is expended only for the purposes for which it is made.

''(4) AUDIT.—The Secretary shall conduct appropriate audits of grants under this section.

''(5) MATCHING REQUIREMENT.—The applicant for a grant under this section shall agree, with respect to the costs to be incurred by the applicant in implementing an electronic prescription drug program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs. Non-Federal contributions under the previous sentence may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2007 and such sums as may be necessary for each of fiscal years 2008 and 2009.''

SUBPART 2—PRESCRIPTION DRUG PLANS; PDP SPONSORS; FINANCING

§ 1395w–111. PDP regions; submission of bids; plan approval

(a) Establishment of PDP regions; service areas

(1) Coverage of entire PDP region

The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

(2) Establishment of PDP regions

(A) In general

The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1395w–27a(a)(2) of this title.

(B) Relation to MA regions

To the extent practicable, PDP regions shall be the same as MA regions under section 1395w–27a(a)(2) of this title. The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

(C) Authority for territories

The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

(3) National plan

Nothing in this subsection shall be construed as preventing a prescription drug plan from being offered in more than one PDP region (including all PDP regions).

(b) Submission of bids, premiums, and related information

(1) In general

A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1395w–24(a) of this title is submitted by an MA organization under paragraph (1) of such section.

(2) Information described

The information described in this paragraph is information on the following:

(A) Coverage provided

The prescription drug coverage provided under the plan, including the deductible and other cost-sharing.

(B) Actuarial value

The actuarial value of the qualified prescription drug coverage in the region for a part D eligible individual with a national average risk profile for the factors described in section 1395w–115(c)(1)(A) of this title (as specified by the Secretary).

(C) Bid

Information on the bid, including an actuarial certification of—

(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

(ii) the portion of such bid attributable to basic prescription drug coverage and, if applicable, the portion of such bid attributable to supplemental benefits;

(iii) assumptions regarding the reinsurance subsidy payments provided under section 1395w–115(b) of this title subtracted from the actuarial value to produce such bid; and

(iv) administrative expenses assumed in the bid.

(D) Service area

The service area for the plan.

(E) Level of risk assumed

(i) In general

Whether the PDP sponsor requires a modification of risk level under clause (ii) and, if so, the extent of such modification. Any such modification shall apply with respect to all prescription drug plans offered by a PDP sponsor in a PDP region. This subparagraph shall not apply to an MA–PD plan.

(ii) Risk levels described

A modification of risk level under this clause may consist of one or more of the following:

(I) Increase in Federal percentage assumed in initial risk corridor

An equal percentage point increase in the percents applied under subparagraphs (B)(i), (B)(ii)(I), (C)(i), and (C)(ii)(I) of section 1395w–115(e)(2) of this title. In no case shall the application of previous sentence prevent the application of a higher percentage under section 1395w–115(e)(2)(B)(iii)[1] of this title.

(II) Increase in Federal percentage assumed in second risk corridor

An equal percentage point increase in the percents applied under subparagraphs (B)(ii)(II) and (C)(ii)(II) of section 1395w–115(e)(2) of this title.

(III) Decrease in size of risk corridors

A decrease in the threshold risk percentages specified in section 1395w–115(e)(3)(C) of this title.

(F) Additional information

Such other information as the Secretary may require to carry out this part.

(3) Paperwork reduction for offering of prescription drug plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of such plans in more than one PDP region (including all regions) through the filing of consolidated information.

[1] See References in Text note below.

(c) Actuarial valuation

(1) Processes

For purposes of this part, the Secretary shall establish processes and methods for determining the actuarial valuation of prescription drug coverage, including—

(A) an actuarial valuation of standard prescription drug coverage under section 1395w–102(b) of this title;

(B) actuarial valuations relating to alternative prescription drug coverage under section 1395w–102(c)(1) of this title;

(C) an actuarial valuation of the reinsurance subsidy payments under section 1395w–115(b) of this title;

(D) the use of generally accepted actuarial principles and methodologies; and

(E) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

(2) Accounting for drug utilization

Such processes and methods for determining actuarial valuation shall take into account the effect that providing alternative prescription drug coverage (rather than standard prescription drug coverage) has on drug utilization.

(3) Responsibilities

(A) Plan responsibilities

PDP sponsors and MA organizations are responsible for the preparation and submission of actuarial valuations required under this part for prescription drug plans and MA–PD plans they offer.

(B) Use of outside actuaries

Under the processes and methods established under paragraph (1), PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

(d) Review of information and negotiation

(1) Review of information

The Secretary shall review the information filed under subsection (b) for the purpose of conducting negotiations under paragraph (2).

(2) Negotiation regarding terms and conditions

Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5.

(3) Rejection of bids

Paragraph (5)(C) of section 1395w–24(a) of this title shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1395w–24(a) of this title.

(e) Approval of proposed plans

(1) In general

After review and negotiation under subsection (d), the Secretary shall approve or disapprove the prescription drug plan.

(2) Requirements for approval

The Secretary may approve a prescription drug plan only if the following requirements are met:

(A) Compliance with requirements

The plan and the PDP sponsor offering the plan comply with the requirements under this part, including the provision of qualified prescription drug coverage.

(B) Actuarial determinations

The Secretary determines that the plan and PDP sponsor meet the requirements under this part relating to actuarial determinations, including such requirements under section 1395w–102(c) of this title.

(C) Application of FEHBP standard

(i) In general

The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to basic prescription drug coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8)(C) of this title) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under section 1395w–115(b) of this title.

(ii) Supplemental coverage

The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to supplemental prescription drug coverage pursuant to section 1395w–102(a)(2) of this title is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8)(C) of this title) for such coverage under the plan.

(D) Plan design

(i) In general

The Secretary does not find that the design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible individuals under the plan.

(ii) Use of categories and classes in formularies

The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

(f) Application of limited risk plans

(1) Conditions for approval of limited risk plans

The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a PDP region if the access requirements under section 1395w–103(a) of this title would not be met for the region but for the approval of such a plan (or a fallback prescription drug plan under subsection (g)).

(2) Rules

The following rules shall apply with respect to the approval of a limited risk plan in a PDP region:

(A) Limited exercise of authority

Only the minimum number of such plans may be approved in order to meet the access requirements under section 1395w–103(a) of this title.

(B) Maximizing assumption of risk

The Secretary shall provide priority in approval for those plans bearing the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

(C) No full underwriting for limited risk plans

In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

(3) Acceptance of all full risk contracts

There shall be no limit on the number of full risk plans that are approved under subsection (e).

(4) Risk-plans defined

For purposes of this subsection:

(A) Limited risk plan

The term ''limited risk plan'' means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in its bid submitted for the plan under such subsection. Such term does not include a fallback prescription drug plan.

(B) Full risk plan

The term ''full risk plan'' means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

(g) Guaranteeing access to coverage

(1) Solicitation of bids

(A) In general

Separate from the bidding process under subsection (b), the Secretary shall provide for a process for the solicitation of bids from eligible fallback entities (as defined in paragraph (2)) for the offering in all fallback service areas (as defined in paragraph (3)) in one or more PDP regions of a fallback prescription drug plan (as defined in paragraph (4)) during the contract period specified in paragraph (5).

(B) Acceptance of bids

(i) In general

Except as provided in this subparagraph, the provisions of subsection (e) shall apply with respect to the approval or disapproval of fallback prescription drug plans. The Secretary shall enter into contracts under this subsection with eligible fallback entities for the offering of fallback prescription drug plans so approved in fallback service areas.

(ii) Limitation of 1 plan for all fallback service areas in a PDP region

With respect to all fallback service areas in any PDP region for a contract period, the Secretary shall approve the offering of only 1 fallback prescription drug plan.

(iii) Competitive procedures

Competitive procedures (as defined in section 132 of title 41) shall be used to enter into a contract under this subsection. The provisions of subsection (d) of section 1395kk–1 of this title shall apply to a contract under this section in the same manner as they apply to a contract under such section.

(iv) Timing

The Secretary shall approve a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan is offered at the same time as prescription drug plans would otherwise be offered.

(V)[2] No national fallback plan

The Secretary shall not enter into a contract with a single fallback entity for the offering of fallback plans throughout the United States.

(2) Eligible fallback entity

For purposes of this section, the term ''eligible fallback entity'' means, with respect to all fallback service areas in a PDP region for a contract period, an entity that—

(A) meets the requirements to be a PDP sponsor (or would meet such requirements but for the fact that the entity is not a risk-bearing entity); and

(B) does not submit a bid under subsection (b) for any prescription drug plan for any PDP region for the first year of such contract period.

For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) Fallback service area

For purposes of this subsection, the term ''fallback service area'' means, for a PDP region with respect to a year, any area within such region for which the Secretary determines before the beginning of the year that the access requirements of the first sentence of section 1395w–103(a) of this title will not be met for part D eligible individuals residing in the area for the year.

(4) Fallback prescription drug plan

For purposes of this part, the term ''fallback prescription drug plan'' means a prescription drug plan that—

(A) only offers the standard prescription drug coverage and access to negotiated prices described in section 1395w–102(a)(1)(A) of this title and does not include any supplemental prescription drug coverage; and

(B) meets such other requirements as the Secretary may specify.

(5) Payments under the contract

(A) In general

A contract entered into under this subsection shall provide for—

(i) payment for the actual costs (taking into account negotiated price concessions described in section 1395w–102(d)(1)(B) of this title) of covered part D drugs provided to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity; and

(ii) payment of management fees that are tied to performance measures established by the Secretary for the management, administration, and delivery of the benefits under the contract.

(B) Performance measures

The performance measures established by the Secretary pursuant to subparagraph (A)(ii) shall include at least measures for each of the following:

(i) Costs

The entity contains costs to the Medicare Prescription Drug Account and to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity through mechanisms such as generic substitution and price discounts.

(ii) Quality programs

The entity provides such enrollees with quality programs that avoid adverse drug reactions and overutilization and reduce medical errors.

(iii) Customer service

The entity provides timely and accurate delivery of services and pharmacy and beneficiary support services.

(iv) Benefit administration and claims adjudication

The entity provides efficient and effective benefit administration and claims adjudication.

(6) Monthly beneficiary premium

Except as provided in section 1395w–113(b) of this title (relating to late enrollment penalty) and subject to section 1395w–114 of this title (relating to low-income assistance), the

[2] So in original. Probably should be ''(v)''.

monthly beneficiary premium to be charged under a fallback prescription drug plan offered in all fallback service areas in a PDP region shall be uniform and shall be equal to 25.5 percent of an amount equal to the Secretary's estimate of the average monthly per capita actuarial cost, including administrative expenses, under the fallback prescription drug plan of providing coverage in the region, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services. In calculating such administrative expenses, the Chief Actuary shall use a factor that is based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

(7) General contract terms and conditions

(A) In general

Except as may be appropriate to carry out this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans under this subsection shall be the same as the terms and conditions of contracts under this part for prescription drug plans.

(B) Period of contract

(i) In general

Subject to clause (ii), a contract approved for a fallback prescription drug plan for fallback service areas for a PDP region under this section shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

(ii) Limitation

A fallback prescription drug plan may be offered under a contract in an area for a year only if that area is a fallback service area for that year.

(C) Entity not permitted to market or brand fallback prescription drug plans

An eligible fallback entity with a contract under this subsection may not engage in any marketing or branding of a fallback prescription drug plan.

(h) Annual report on use of limited risk plans and fallback plans

The Secretary shall submit to Congress an annual report that describes instances in which limited risk plans and fallback prescription drug plans were offered under subsections (f) and (g). The Secretary shall include in such report such recommendations as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk under section subsection[3] (f).

(i) Noninterference

In order to promote competition under this part and in carrying out this part, the Secretary—

(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

[3] So in original.

(j) Coordination of benefits

A PDP sponsor offering a prescription drug plan shall permit State Pharmaceutical Assistance Programs and Rx plans under sections 1395w–133 and 1395w–134 of this title to coordinate benefits with the plan and, in connection with such coordination with such a Program, not to impose fees that are unrelated to the cost of coordination.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–11, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2092; amended Pub. L. 111–148, title III, §3209(b), Mar. 23, 2010, 124 Stat. 460.)

Editorial Notes

REFERENCES IN TEXT

Section 1395w–115(e)(2)(B)(iii) of this title, referred to in subsec. (b)(2)(E)(ii)(I), was in the original ''section 1869D–15(e)(2)(B)(iii)'', and was translated as reading ''section 1860D–15(e)(2)(B)(iii)'', meaning 1860D–15(e)(2)(B)(iii) of the Social Security Act, to reflect the probable intent of Congress, because the Social Security Act does not contain a section 1869D–15 and section 1395w–115(e)(2)(B)(iii) of this title provides for an application of a higher percentage for years 2006 and 2007.

CODIFICATION

In subsec. (g)(1)(B)(iii), ''section 132 of title 41'' substituted for ''section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))'' on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2010—Subsec. (d)(3). Pub. L. 111–148 added par. (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 applicable to bids submitted for contract years beginning on or after Jan. 1, 2011, see section 3209(c) of Pub. L. 111–148, set out as a note under section 1395w–24 of this title.

STUDY REGARDING REGIONAL VARIATIONS IN PRESCRIPTION DRUG SPENDING

Pub. L. 108–173, title I, §107(a), Dec. 8, 2003, 117 Stat. 2169, provided that:

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct a study that examines variations in per capita spending for covered part D drugs under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] among PDP regions and, with respect to such spending, the amount of such variation that is attributable to—

''(A) price variations (described in section 1860D–15(c)(2) of such Act [42 U.S.C. 1395w–115(c)(2)]); and

''(B) differences in per capita utilization that is not taken into account in the health status risk adjustment provided under section 1860D–15(c)(1) of such Act [42 U.S.C. 1395w–115(c)(1)].

''(2) REPORT AND RECOMMENDATIONS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include—

''(A) information regarding the extent of geographic variation described in paragraph (1)(B);

''(B) an analysis of the impact on direct subsidies under section 1860D–15(a)(1) of the Social Security Act [42 U.S.C. 1395w–115(a)(1)] in different PDP regions if such subsidies were adjusted to take into account the variation described in subparagraph (A); and

''(C) recommendations regarding the appropriateness of applying an additional geographic adjustment factor under section 1860D–15(c)(2) [42 U.S.C. 1395w–115(c)(2)] that reflects some or all of the variation described in subparagraph (A).''

§ 1395w–112. Requirements for and contracts with prescription drug plan (PDP) sponsors

(a) General requirements

Each PDP sponsor of a prescription drug plan shall meet the following requirements:

(1) Licensure

Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

(2) Assumption of financial risk for unsubsidized coverage

(A) In general

Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a prescription drug plan and that is not covered under section 1395w–115(b) of this title.

(B) Reinsurance permitted

The plan sponsor may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee to the extent that the sponsor is at risk for providing such coverage.

(3) Solvency for unlicensed sponsors

In the case of a PDP sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

(b) Contract requirements

(1) In general

The Secretary shall not permit the enrollment under section 1395w–101 of this title in a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1395w–114 or 1395w–115 of this title, unless the Secretary has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(2) Limitation on entities offering fallback prescription drug plans

The Secretary shall not enter into a contract with a PDP sponsor for the offering of a prescription drug plan (other than a fallback prescription drug plan) in a PDP region for a year if the sponsor—

(A) submitted a bid under section 1395w–111(g) of this title for such year (as the first year of a contract period under such section) to offer a fallback prescription drug plan in any PDP region;

(B) offers a fallback prescription drug plan in any PDP region during the year; or

(C) offered a fallback prescription drug plan in that PDP region during the previous year.

For purposes of this paragraph, an entity shall be treated as submitting a bid with respect to a prescription drug plan or offering a fallback prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) Incorporation of certain medicare advantage contract requirements

Except as otherwise provided, the following provisions of section 1395w–27 of this title shall apply to contracts under this section in the same manner as they apply to contracts under section 1395w–27(a) of this title:

(A) Minimum enrollment

Paragraphs (1) and (3) of section 1395w–27(b) of this title, except that—

(i) the Secretary may increase the minimum number of enrollees required under such paragraph (1) as the Secretary determines appropriate; and

(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

(B) Contract period and effectiveness

Section 1395w–27(c) of this title, except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1395w–23 of this title shall be deemed payment amounts under section 1395w–115 of this title.

(C) Protections against fraud and beneficiary protections

Section 1395w–27(d) of this title.

(D) Additional contract terms

Section 1395w–27(e) of this title; except that section 1395w–27(e)(2) of this title shall apply as specified to PDP sponsors and payments under this part to an MA–PD plan shall be treated as expenditures made under part D. Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1395w–27(e)(1) of this title to contracts under this section under the preceding sentence—

(i) may be used for the purposes of carrying out this part, improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services (as the Secretary determines appropriate); and

(ii) shall be made available to Congressional[1] support agencies (in accordance with their obligations to support Congress as set out in their authorizing statutes) for the purposes of conducting Congressional[1]

[1] So in original. Probably should not be capitalized.

oversight, monitoring, making recommendations, and analysis of the program under this subchapter.

(E) Intermediate sanctions

Section 1395w–27(g) of this title (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1395w–27(g)(1)(B) of this title to section 1395w–24 of this title is deemed a reference to this part.

(F) Procedures for termination

Section 1395w–27(h) of this title.

(4) Prompt payment of clean claims

(A) Prompt payment

(i) In general

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility) under this part within the applicable number of calendar days after the date on which the claim is received.

(ii) Clean claim defined

In this paragraph, the term ''clean claim'' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(iii) Date of receipt of claim

In this paragraph, a claim is considered to have been received—

(I) with respect to claims submitted electronically, on the date on which the claim is transferred; and

(II) with respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission.

(B) Applicable number of calendar days defined

In this paragraph, the term ''applicable number of calendar days'' means—

(i) with respect to claims submitted electronically, 14 days; and

(ii) with respect to claims submitted otherwise, 30 days.

(C) Interest payment

(i) In general

Subject to clause (ii), if payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in subparagraph (B)) after a clean claim is received, the PDP sponsor shall pay interest to the pharmacy that submitted the claim at a rate equal to the weighted average of interest on 3-month marketable Treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment is made (as determined under subparagraph (D)(iv)). Interest amounts paid under this subparagraph shall not be counted against the administrative costs of a prescription drug plan or treated as allowable risk corridor costs under section 1395w–115(e) of this title.

(ii) Authority not to charge interest

The Secretary may provide that a PDP sponsor is not charged interest under clause (i) in the case where there are exigent circumstances, including natural disasters and other unique and unexpected events, that prevent the timely processing of claims.

(D) Procedures involving claims

(i) Claim deemed to be clean

A claim is deemed to be a clean claim if the PDP sponsor involved does not provide notice to the claimant of any deficiency in the claim—

(I) with respect to claims submitted electronically, within 10 days after the date on which the claim is received; and

(II) with respect to claims submitted otherwise, within 15 days after the date on which the claim is received.

(ii) Claim determined to not be a clean claim

(I) In general

If a PDP sponsor determines that a submitted claim is not a clean claim, the PDP sponsor shall, not later than the end of the period described in clause (i), notify the claimant of such determination. Such notification shall specify all defects or improprieties in the claim and shall list all additional information or documents necessary for the proper processing and payment of the claim.

(II) Determination after submission of additional information

A claim is deemed to be a clean claim under this paragraph if the PDP sponsor involved does not provide notice to the claimant of any defect or impropriety in the claim within 10 days of the date on which additional information is received under subclause (I).

(iii) Obligation to pay

A claim submitted to a PDP sponsor that is not paid or contested by the sponsor within the applicable number of days (as defined in subparagraph (B)) after the date on which the claim is received shall be deemed to be a clean claim and shall be paid by the PDP sponsor in accordance with subparagraph (A).

(iv) Date of payment of claim

Payment of a clean claim under such subparagraph is considered to have been made on the date on which—

(I) with respect to claims paid electronically, the payment is transferred; and

(II) with respect to claims paid otherwise, the payment is submitted to the United States Postal Service or common carrier for delivery.

(E) Electronic transfer of funds

A PDP sponsor shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy so requests or has so requested previously. In the case where such payment is made electronically, remittance may be made by the PDP sponsor electronically as well.

(F) Protecting the rights of claimants

(i) In general

Nothing in this paragraph shall be construed to prohibit or limit a claim or action not covered by the subject matter of this section that any individual or organization has against a provider or a PDP sponsor.

(ii) Anti-retaliation

Consistent with applicable Federal or State law, a PDP sponsor shall not retaliate against an individual or provider for exercising a right of action under this subparagraph.

(G) Rule of construction

A determination under this paragraph that a claim submitted by a pharmacy is a clean claim shall not be construed as a positive determination regarding eligibility for payment under this subchapter, nor is it an indication of government approval of, or acquiescence regarding, the claim submitted. The determination shall not relieve any party of civil or criminal liability with respect to the claim, nor does it offer a defense to any administrative, civil, or criminal action with respect to the claim.

(5) Submission of claims by pharmacies located in or contracting with long-term care facilities

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that a pharmacy located in, or having a contract with, a long-term care facility shall have not less than 30 days (but not more than 90 days) to submit claims to the sponsor for reimbursement under the plan.

(6) Regular update of prescription drug pricing standard

If the PDP sponsor of a prescription drug plan uses a standard for reimbursement of pharmacies based on the cost of a drug, each contract entered into with such sponsor under this part with respect to the plan shall provide that the sponsor shall update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.

(7) Suspension of payments pending investigation of credible allegations of fraud by pharmacies

(A) In general

Section 1395y(*o*)(1) of this title shall apply with respect to a PDP sponsor with a contract under this part, a pharmacy, and payments to such pharmacy under this part in the same manner as such section applies with respect to the Secretary, a provider of services or supplier, and payments to such provider of services or supplier under this subchapter. A PDP sponsor shall notify the Secretary regarding the imposition of any payment suspension pursuant to the previous sentence, such as through the secure internet website portal (or other successor technology) established under section 1395w–28(i) of this title.

(B) Rule of construction

Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.

(c) Waiver of certain requirements to expand choice

(1) Authorizing waiver

(A) In general

In the case of an entity that seeks to offer a prescription drug plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

(B) Application of regional plan waiver rule

In addition to the waiver available under subparagraph (A), the provisions of section 1395w–27a(d) of this title shall apply to PDP sponsors under this part in a manner similar to the manner in which such provisions apply to MA organizations under part C, except that no application shall be required under paragraph (1)(B) of such section in the case of a State that does not provide a licensing process for such a sponsor.

(2) Grounds for approval

(A) In general

The grounds for approval under this paragraph are—

(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1395w–25(a)(2) of this title; and

(ii) the application by a State of any grounds other than those required under Federal law.

(B) Special rules

In applying subparagraph (A)(i)—

(i) the ground of approval described in section 1395w–25(a)(2)(B) of this title is deemed to have been met if the State does not have a licensing process in effect with respect to the PDP sponsor; and

(ii) for plan years beginning before January 1, 2008, if the State does have such a li-

censing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

(3) Application of waiver procedures

With respect to an application for a waiver (or a waiver granted) under paragraph (1)(A) of this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1395w–25(a)(2) of this title shall apply, except that clauses (i) and (ii) of such subparagraph (E) shall not apply in the case of a State that does not have a licensing process described in paragraph (2)(B)(i) in effect.

(4) References to certain provisions

In applying provisions of section 1395w–25(a)(2) of this title under paragraphs (2) and (3) of this subsection to prescription drug plans and PDP sponsors—

(A) any reference to a waiver application under section 1395w–25 of this title shall be treated as a reference to a waiver application under paragraph (1)(A) of this subsection; and

(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

(d) Solvency standards for non-licensed entities

(1) Establishment and publication

The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

(2) Compliance with standards

A PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish certification procedures for such sponsors with respect to such solvency standards in the manner described in section 1395w–25(c)(2) of this title.

(e) Licensure does not substitute for or constitute certification

The fact that a PDP sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this part for a sponsor.

(f) Periodic review and revision of standards

(1) In general

Subject to paragraph (2), the Secretary may periodically review the standards established under this section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

(2) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a PDP sponsor or a prescription drug plan.

(g) Prohibition of State imposition of premium taxes; relation to State laws

The provisions of sections 1395w–24(g) and 1395w–26(b)(3) of this title shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–12, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2099; amended Pub. L. 110–275, title I, §§171(a), 172(a)(1), 173(a), 181, July 15, 2008, 122 Stat. 2578, 2580–2582; Pub. L. 115–271, title II, §2008(a), Oct. 24, 2018, 132 Stat. 3931.)

Editorial Notes

AMENDMENTS

2018—Subsec. (b)(7). Pub. L. 115–271 added par. (7).

2008—Subsec. (b)(3)(D). Pub. L. 110–275, §181, inserted at end ''Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1395w–27(e)(1) of this title to contracts under this section under the preceding sentence—'' and added cls. (i) and (ii).

Subsec. (b)(4). Pub. L. 110–275, §171(a), added par. (4).

Subsec. (b)(5). Pub. L. 110–275, §172(a)(1), added par. (5).

Subsec. (b)(6). Pub. L. 110–275, §173(a), added par. (6).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 2008(a) of Pub. L. 115–271 applicable with respect to plan years beginning on or after Jan. 1, 2020, see section 2008(e) of Pub. L. 115–271, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 171(a) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, see section 171(c) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

Amendment by section 172(a)(1) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, see section 172(b) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

Amendment by section 173(a) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 173(c) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

§ 1395w–113. Premiums; late enrollment penalty

(a) Monthly beneficiary premium

(1) Computation

(A) In general

The monthly beneficiary premium for a prescription drug plan is the base beneficiary premium computed under paragraph (2) as adjusted under this paragraph.

(B) Adjustment to reflect difference between bid and national average bid

(i) Above average bid

If for a month the amount of the standardized bid amount (as defined in paragraph (5)) exceeds the amount of the adjusted national average monthly bid amount (as defined in clause (iii)), the base beneficiary premium for the month shall be increased by the amount of such excess.

(ii) Below average bid

If for a month the amount of the adjusted national average monthly bid amount for the month exceeds the standardized bid amount, the base beneficiary premium for the month shall be decreased by the amount of such excess.

(iii) Adjusted national average monthly bid amount defined

For purposes of this subparagraph, the term ''adjusted national average monthly bid amount'' means the national average monthly bid amount computed under paragraph (4), as adjusted under section 1395w–115(c)(2) of this title.

(C) Increase for supplemental prescription drug benefits

The base beneficiary premium shall be increased by the portion of the PDP approved bid that is attributable to supplemental prescription drug benefits.

(D) Increase for late enrollment penalty

The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (b).

(E) Decrease for low-income assistance

The monthly beneficiary premium is subject to decrease in the case of a subsidy eligible individual under section 1395w–114 of this title.

(F) Increase based on income

The monthly beneficiary premium shall be increased pursuant to paragraph (7).

(G) Uniform premium

Except as provided in subparagraphs (D), (E), and (F), the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

(2) Base beneficiary premium

The base beneficiary premium under this paragraph for a prescription drug plan for a month is equal to the product[1]—

(A) the beneficiary premium percentage (as specified in paragraph (3)); and

(B) the national average monthly bid amount (computed under paragraph (4)) for the month.

(3) Beneficiary premium percentage

For purposes of this subsection, the beneficiary premium percentage for any year is the percentage equal to a fraction—

(A) the numerator of which is 25.5 percent; and

(B) the denominator of which is 100 percent minus a percentage equal to—

(i) the total reinsurance payments which the Secretary estimates are payable under section 1395w–115(b) of this title with respect to the coverage year; divided by

(ii) the sum of—

(I) the amount estimated under clause (i) for the year; and

(II) the total payments which the Secretary estimates will be paid to prescription drug plans and MA–PD plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by the Secretary and enrollees.

(4) Computation of national average monthly bid amount

(A) In general

For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title. Such average does not take into account the bids submitted for MSA plans, MA private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1395eee of this title (pursuant to section 1395w–131(f) of this title), and under reasonable cost reimbursement contracts under section 1395mm(h) of this title (pursuant to section 1395w–131(e) of this title).

(B) Weighted average

(i) In general

The monthly national average monthly bid amount computed under subparagraph (A) for a year shall be a weighted average, with the weight for each plan being equal to the average number of part D eligible individuals enrolled in such plan in the reference month (as defined in section 1395w–27a(f)(4) of this title).

(ii) Special rule for 2006

For purposes of applying this paragraph for 2006, the Secretary shall establish procedures for determining the weighted average under clause (i) for 2005.

(5) Standardized bid amount defined

For purposes of this subsection, the term ''standardized bid amount'' means the following:

(A) Prescription drug plans

(i) Basic coverage

In the case of a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid (as defined in paragraph (6)).

(ii) Supplemental coverage

In the case of a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage.

(B) MA–PD plans

In the case of an MA–PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

(6) PDP approved bid defined

For purposes of this part, the term ''PDP approved bid'' means, with respect to a prescrip-

[1] So in original. The word ''of'' probably should appear after ''product''.

tion drug plan, the bid amount approved for the plan under this part.

(7) Increase in base beneficiary premium based on income

(A) In general

In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1395r(i) of this title (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

(B) Monthly adjustment amount

The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

(i) the quotient obtained by dividing—

(I) the applicable percentage determined under paragraph (3)(C) of section 1395r(i) of this title (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

(II) 25.5 percent; and

(ii) the base beneficiary premium (as computed under paragraph (2)).

(C) Modified adjusted gross income

For purposes of this paragraph, the term ''modified adjusted gross income'' has the meaning given such term in subparagraph (A) of section 1395r(i)(4) of this title, determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

(D) Determination by Commissioner of Social Security

The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(E) Procedures to assure correct income-related increase in base beneficiary premium

(i) Disclosure of base beneficiary premium

Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

(ii) Additional disclosure

Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1395r(i) of this title (including application of paragraph (5) of such section).

(II) The applicable percentage determined under paragraph (3)(C) of section 1395r(i) of this title (including application of paragraph (5) of such section).

(III) The monthly adjustment amount specified in subparagraph (B).

(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(F) Rule of construction

The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.

(b) Late enrollment penalty

(1) In general

Subject to the succeeding provisions of this subsection, in the case of a part D eligible individual described in paragraph (2) with respect to a continuous period of eligibility, there shall be an increase in the monthly beneficiary premium established under subsection (a) in an amount determined under paragraph (3).

(2) Individuals subject to penalty

A part D eligible individual described in this paragraph is, with respect to a continuous period of eligibility, an individual for whom there is a continuous period of 63 days or longer (all of which in such continuous period of eligibility) beginning on the day after the last date of the individual's initial enrollment period under section 1395w–101(b)(2) of this title and ending on the date of enrollment under a prescription drug plan or MA–PD plan during all of which the individual was not covered under any creditable prescription drug coverage.

(3) Amount of penalty

(A) In general

The amount determined under this paragraph for a part D eligible individual for a continuous period of eligibility is the greater of—

(i) an amount that the Secretary determines is actuarially sound for each uncovered month (as defined in subparagraph (B)) in the same continuous period of eligibility; or

(ii) 1 percent of the base beneficiary premium (computed under subsection (a)(2)) for each such uncovered month in such period.

(B) Uncovered month defined

For purposes of this subsection, the term ''uncovered month'' means, with respect to a part D eligible individual, any month beginning after the end of the initial enrollment period under section 1395w–101(b)(2) of this title unless the individual can demonstrate that the individual had creditable prescrip-

tion drug coverage (as defined in paragraph (4)) for any portion of such month.

(4) Creditable prescription drug coverage defined

For purposes of this part, the term ''creditable prescription drug coverage'' means any of the following coverage, but only if the coverage meets the requirement of paragraph (5):

(A) Coverage under prescription drug plan or MA–PD plan

Coverage under a prescription drug plan or under an MA–PD plan.

(B) Medicaid

Coverage under a medicaid plan under subchapter XIX or under a waiver under section 1315 of this title.

(C) Group health plan

Coverage under a group health plan, including a health benefits plan under chapter 89 of title 5 (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title).

(D) State pharmaceutical assistance program

Coverage under a State pharmaceutical assistance program described in section 1395w–133(b)(1) of this title.

(E) Veterans' coverage of prescription drugs

Coverage for veterans, and survivors and dependents of veterans, under chapter 17 of title 38.

(F) Prescription drug coverage under medigap policies

Coverage under a medicare supplemental policy under section 1395ss of this title that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1395ss(p)(1) of this title).

(G) Military coverage (including TRICARE)

Coverage under chapter 55 of title 10.

(H) Other coverage

Such other coverage as the Secretary determines appropriate.

(5) Actuarial equivalence requirement

Coverage meets the requirement of this paragraph only if the coverage is determined (in a manner specified by the Secretary) to provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the individual equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1395w–111(c) of this title).

(6) Procedures to document creditable prescription drug coverage

(A) In general

The Secretary shall establish procedures (including the form, manner, and time) for the documentation of creditable prescription drug coverage, including procedures to assist in determining whether coverage meets the requirement of paragraph (5).

(B) Disclosure by entities offering creditable prescription drug coverage

(i) In general

Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.

(ii) Disclosure of non-creditable coverage

In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA–PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

(C) Waiver of requirement

In the case of a part D eligible individual who was enrolled in prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) which is not creditable prescription drug coverage because it does not meet the requirement of paragraph (5), the individual may apply to the Secretary to have such coverage treated as creditable prescription drug coverage if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

(7) Continuous period of eligibility

(A) In general

Subject to subparagraph (B), for purposes of this subsection, the term ''continuous period of eligibility'' means, with respect to a part D eligible individual, the period that begins with the first day on which the individual is eligible to enroll in a prescription drug plan under this part and ends with the individual's death.

(B) Separate period

Any period during all of which a part D eligible individual is entitled to hospital insurance benefits under part A and—

(i) which terminated in or before the month preceding the month in which the individual attained age 65; or

(ii) for which the basis for eligibility for such entitlement changed between section 426(b) of this title and section 426(a) of this title, between 426(b)[2] of this title and section 426–1 of this title, or between section 426–1 of this title and section 426(a) of this title,

shall be a separate continuous period of eligibility with respect to the individual (and

[2] So in original. Probably should be ''section 426(b)''.

each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

(8) Waiver of penalty for subsidy-eligible individuals

In no case shall a part D eligible individual who is determined to be a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title) be subject to an increase in the monthly beneficiary premium established under subsection (a).

(c) Collection of monthly beneficiary premiums

(1) In general

Subject to paragraphs (2), (3), and (4), the provisions of section 1395w–24(d) of this title shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

(2) Crediting of late enrollment penalty

(A) Portion attributable to increased actuarial costs

With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or MA organization (and not taken into account through risk adjustment provided under section 1395w–115(c)(1) of this title or through reinsurance payments under section 1395w–115(b) of this title) as a result of such late enrollment.

(B) Collection through withholding

In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1395w–24(d)(2)(A) of this title, the Secretary shall provide that only the portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or MA organization offering the part D plan in which the individual is enrolled.

(C) Collection by plan

In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1395w–24(d)(2)(A) of this title, the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or MA organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

(3) Fallback plans

In applying this subsection in the case of a fallback prescription drug plan, paragraph (2) shall not apply and the monthly beneficiary premium shall be collected in the manner specified in section 1395w–24(d)(2)(A) of this title (or such other manner as may be provided under section 1395s of this title in the case of monthly premiums under section 1395r of this title).

(4) Collection of monthly adjustment amount

(A) In general

Notwithstanding any provision of this subsection or section 1395w–24(d)(2) of this title, subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1395s of this title.

(B) Agreements

In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–13, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2102; amended Pub. L. 110–275, title I, §114(a)(1), July 15, 2008, 122 Stat. 2506; Pub. L. 111–148, title III, §3308(a), (b)(1), Mar. 23, 2010, 124 Stat. 472, 474.)

Editorial Notes

AMENDMENTS

2010—Subsec. (a)(1)(F), (G). Pub. L. 111–148, §3308(b)(1), added subpar. (F), redesignated former subpar. (F) as (G), and substituted ''(D), (E), and (F)'' for ''(D) and (E)'' in subpar. (G).

Subsec. (a)(7). Pub. L. 111–148, §3308(a)(1), added par. (7).

Subsec. (c)(1). Pub. L. 111–148, §3308(a)(2)(A), substituted ''(2), (3), and (4)'' for ''(2) and (3)''.

Subsec. (c)(4). Pub. L. 111–148, §3308(a)(2)(B), added par. (4).

2008—Subsec. (b)(8). Pub. L. 110–275 added par. (8).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §114(b), July 15, 2008, 122 Stat. 2507, provided that: ''The amendments made by this section [amending this section and section 1395w–114 of this title] shall apply to subsidies for months beginning with January 2009.''

§ 1395w–114. Premium and cost-sharing subsidies for low-income individuals

(a) Income-related subsidies for individuals with income up to 150 percent of poverty line

(1) Individuals with income below 135 percent of poverty line

In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

(A) Full premium subsidy

An income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B).

(B) Elimination of deductible

A reduction in the annual deductible applicable under section 1395w–102(b)(1) of this title to $0.

(C) Continuation of coverage above the initial coverage limit

The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1395w–102(b) of this title) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced cost-sharing described in subparagraph (D).

(D) Reduction in cost-sharing below out-of-pocket threshold

(i) Institutionalized individuals

In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1396a(q)(1)(B) of this title) or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1315 of this title or subsection (c) or (d) of section 1396n of this title or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1396b(m) of this title or under section 1396u–2 of this title, the elimination of any beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title).

(ii) Lowest income dual eligible individuals

In the case of an individual not described in clause (i) who is a full-benefit dual eligible individual and whose income does not exceed 100 percent of the poverty line applicable to a family of the size involved, the substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of a copayment amount that does not exceed $1 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title) and $3 for any other drug, or, if less, the copayment amount applicable to an individual under clause (iii).

(iii) Other individuals

In the case of an individual not described in clause (i) or (ii), the substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of a copayment amount that does not exceed the copayment amount specified under section 1395w–102(b)(4)(A)(i)(I) of this title for the drug and year involved.

(E) Elimination of cost-sharing above annual out-of-pocket threshold

The elimination of any cost-sharing imposed under section 1395w–102(b)(4)(A) of this title.

(2) Other individuals with income below 150 percent of poverty line

In the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

(A) Sliding scale premium subsidy

An income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in paragraph (1)(A) for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

(B) Reduction of deductible

A reduction in the annual deductible applicable under section 1395w–102(b)(1) of this title to $50.

(C) Continuation of coverage above the initial coverage limit

The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1395w–102(b) of this title) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced coinsurance described in subparagraph (D).

(D) Reduction in cost-sharing below out-of-pocket threshold

The substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts above the deductible under subparagraph (B) through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of coinsurance of ''15 percent'' instead of coinsurance of ''25 percent'' in section 1395w–102(b)(2) of this title.

(E) Reduction of cost-sharing above annual out-of-pocket threshold

Subject to subsection (c), the substitution for the cost-sharing imposed under section 1395w–102(b)(4)(A) of this title of a copayment or coinsurance not to exceed the copayment or coinsurance amount specified under section 1395w–102(b)(4)(A)(i)(I) of this title for the drug and year involved.

(3) Determination of eligibility

(A) Subsidy eligible individual defined

For purposes of this part, subject to subparagraph (F), the term ''subsidy eligible individual'' means a part D eligible individual who—

(i) is enrolled in a prescription drug plan or MA–PD plan;

(ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and

(iii) meets the resources requirement described in subparagraph (D) or (E).

(B) Determinations

(i) In general

The determination of whether a part D eligible individual residing in a State is a subsidy eligible individual and whether the individual is described in paragraph (1) shall be determined under the State plan under subchapter XIX for the State under section 1396u–5(a) of this title or by the Commissioner of Social Security. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

(ii) Effective period

Determinations under this subparagraph shall be effective beginning with the month in which the individual applies for a determination that the individual is a subsidy eligible individual and shall remain in effect for a period specified by the Secretary, but not to exceed 1 year.

(iii) Redeterminations and appeals through medicaid

Redeterminations and appeals, with respect to eligibility determinations under clause (i) made under a State plan under subchapter XIX, shall be made in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under such plan for purposes of medical assistance under such subchapter.

(iv) Redeterminations and appeals through Commissioner

With respect to eligibility determinations under clause (i) made by the Commissioner of Social Security—

(I) redeterminations shall be made at such time or times as may be provided by the Commissioner;

(II) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1383(c)(1)(A) of this title; and

(III) judicial review of the final decision of the Commissioner made after a hearing shall be available to the same extent, and with the same limitations, as provided in subsections (g) and (h) of section 405 of this title.

(v) Treatment of medicaid beneficiaries

Subject to subparagraph (F), the Secretary—

(I) shall provide that part D eligible individuals who are full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title) or who are recipients of supplemental security income benefits under subchapter XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

(II) may provide that part D eligible individuals not described in subclause (I) who are determined for purposes of the State plan under subchapter XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1396a(a)(10)(E) of this title are treated as being determined to be subsidy eligible individuals described in paragraph (1).

Insofar as the Secretary determines that the eligibility requirements under the State plan for medical assistance referred to in subclause (II) are substantially the same as the requirements for being treated as a subsidy eligible individual described in paragraph (1), the Secretary shall provide for the treatment described in such subclause.

(vi) Special rule for widows and widowers

Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.

(C) Income determinations

For purposes of applying this section—

(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1396d(p)(1)(B) of this title, without regard to the application of section 1396a(r)(2) of this title and except that support and maintenance furnished in kind shall not be counted as income; and

(ii) the term ''poverty line'' has the meaning given such term in section 9902(2) of this title, including any revision required by such section.

Nothing in clause (i) shall be construed to affect the application of section 1396a(r)(2) of this title for the determination of eligibility for medical assistance under subchapter XIX.

(D) Resource standard applied to full low-income subsidy to be based on three times SSI resource standard

The resources requirement of this subparagraph is that an individual's resources (as determined under section 1382b of this title for purposes of the supplemental security income program subject to the life insurance policy exclusion provided under subparagraph (G)) do not exceed—

(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(E) Alternative resource standard

(i) In general

The resources requirement of this subparagraph is that an individual's resources (as determined under section 1382b of this title for purposes of the supplemental security income program subject to the life insurance policy exclusion provided under subparagraph (G)) do not exceed—

(I) for 2006, $10,000 (or $20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

(II) for a subsequent year the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any dollar amount established under subclause (II) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(ii) Use of simplified application form and process

The Secretary, jointly with the Commissioner of Social Security, shall—

(I) develop a model, simplified application form and process consistent with clause (iii) for the determination and verification of a part D eligible individual's assets or resources under this subparagraph; and

(II) provide such form to States.

(iii) Documentation and safeguards

Under such process—

(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

(III) matters attested to in the application shall be subject to appropriate methods of verification.

(iv) Methodology flexibility

The Secretary may permit a State in making eligibility determinations for premium and cost-sharing subsidies under this section to use the same asset or resource methodologies that are used with respect to eligibility for medical assistance for medicare cost-sharing described in section 1396d(p) of this title so long as the Secretary determines that the use of such methodologies will not result in any significant differences in the number of individuals determined to be subsidy eligible individuals.

(F) Treatment of territorial residents

In the case of a part D eligible individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual under this section but may be eligible for financial assistance with prescription drug expenses under section 1396u–5(e) of this title.

(G) Life insurance policy exclusion

In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1382b of this title for purposes of subparagraphs (D) and (E) no part of the value of any life insurance policy shall be taken into account.

(4) Indexing dollar amounts

(A) Copayment for lowest income dual eligible individuals

The dollar amounts applied under paragraph (1)(D)(ii)—

(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; or

(ii) for a subsequent year shall be the dollar amounts specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any amount established under clause (i) or (ii), that is based on an increase of $1 or $3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

(B) Reduced deductible

The dollar amount applied under paragraph (2)(B)—

(i) for 2007 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1395w–102(b)(6) of this title for 2007; or

(ii) for a subsequent year shall be the dollar amount specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase described in section 1395w–102(b)(6) of this title for the year involved.

Any amount established under clause (i) or (ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

(5) Waiver of de minimis premiums

The Secretary shall, under procedures established by the Secretary, permit a prescription

drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.

(b) Premium subsidy amount

(1) In general

The premium subsidy amount described in this subsection for a subsidy eligible individual residing in a PDP region and enrolled in a prescription drug plan or MA–PD plan is the low-income benchmark premium amount (as defined in paragraph (2)) for the PDP region in which the individual resides or, if greater, the amount specified in paragraph (3).

(2) Low-income benchmark premium amount defined

(A) In general

For purposes of this subsection, the term ''low-income benchmark premium amount'' means, with respect to a PDP region in which—

(i) all prescription drug plans are offered by the same PDP sponsor, the weighted average of the amounts described in subparagraph (B)(i) for such plans; or

(ii) there are prescription drug plans offered by more than one PDP sponsor, the weighted average of amounts described in subparagraph (B) for prescription drug plans and MA–PD plans described in section 1395w–21(a)(2)(A)(i) of this title offered in such region.

(B) Premium amounts described

The premium amounts described in this subparagraph are, in the case of—

(i) a prescription drug plan that is a basic prescription drug plan, the monthly beneficiary premium for such plan;

(ii) a prescription drug plan that provides alternative prescription drug coverage the actuarial value of which is greater than that of standard prescription drug coverage, the portion of the monthly beneficiary premium that is attributable to basic prescription drug coverage; and

(iii) an MA–PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1395w–22(a)(6)(B)(ii)[1] of this title) and determined before the application of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year involved and, in the case of a qualifying plan, before the application of the increase under section 1395w–23(*o*) of this title for that plan and year involved.

The premium amounts described in this subparagraph do not include any amounts attributable to late enrollment penalties under section 1395w–113(b) of this title.

(3) Access to 0 premium plan

In no case shall the premium subsidy amount under this subsection for a PDP region be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the region.

(c) Administration of subsidy program

(1) In general

The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA–PD plan—

(A) the Secretary provides for a notification of the PDP sponsor or the MA organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

(B) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Secretary information on the amount of such reduction;

(C) the Secretary periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions; and

(D) the Secretary ensures the confidentiality of individually identifiable information.

In applying subparagraph (C), the Secretary shall compute reductions based upon imposition under subsections (a)(1)(D) and (a)(2)(E) of unreduced copayment amounts applied under such subsections.

(2) Use of capitated form of payment

The reimbursement under this section with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

(d) Facilitation of reassignments

Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1395w–104(g) of this title, bring an appeal under section 1395w–104(h) of this title, or resolve a grievance under section 1395w–104(f) of this title.

(e) Limited income newly eligible transition program

(1) In general

Beginning not later than January 1, 2024, the Secretary shall carry out a program to provide

[1] So in original. Section 1395w–22(a)(6) of this title does not contain a subpar. (B).

transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

(2) LI NET eligible individual defined

For purposes of this subsection, the term ''LI NET eligible individual'' means a part D eligible individual who—

(A) meets the requirements of clauses (ii) and (iii) of subsection (a)(3)(A); and

(B) has not yet enrolled in a prescription drug plan or an MA–PD plan, or, who has so enrolled, but with respect to whom coverage under such plan has not yet taken effect.

(3) Transitional coverage

For purposes of this subsection, the term ''transitional coverage'' means with respect to an LI NET eligible individual—

(A) immediate access to covered part D drugs at the point of sale during the period that begins on the first day of the month such individual is determined to meet the requirements of clauses (ii) and (iii) of subsection (a)(3)(A) and ends on the date that coverage under a prescription drug plan or MA–PD plan takes effect with respect to such individual; and

(B) in the case of an LI NET eligible individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) or a recipient of supplemental security income benefits under subchapter XVI, retroactive coverage (in the form of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs purchased by such individual during the period that begins on the date that is the later of—

(i) the date that such individual was first eligible for a low-income subsidy under this part; or

(ii) the date that is 36 months prior to the date such individual enrolls in a prescription drug plan or MA–PD plan,

and ends on the date that coverage under such plan takes effect.

(4) Program administration

(A) Point of contact

The Secretary shall, as determined appropriate by the Secretary, administer the program under this subsection through a contract with a single program administrator.

(B) Benefit design

The Secretary shall ensure that the transitional coverage provided to LI NET eligible individuals under this subsection—

(i) provides access to all covered part D drugs under an open formulary;

(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and

(iv) meets such other requirements as the Secretary may establish.

(5) Relationship to other provisions of this subchapter; waiver authority

(A) In general

The following provisions shall not apply with respect to the program under this subsection:

(i) Paragraphs (1) and (3)(B) of section 1395w–104(a) of this title (relating to dissemination of general information; availability of information on changes in formulary through the internet).

(ii) Subparagraphs (A) and (B) of section 1395w–104(b)(3) of this title (relating to requirements on development and application of formularies; formulary development).

(iii) Paragraphs (1)(C) and (2) of section 1395w–104(c) of this title (relating to medication therapy management program).

(B) Waiver authority

The Secretary may waive such other requirements of subchapter XI and this subchapter as may be necessary to carry out the purposes of the program established under this subsection.

(6) Contracting authority

The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(f) Relation to medicaid program

For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1396u–5 of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2107; amended Pub. L. 110–275, title I, §§114(a)(2), 116(a), 117(a), July 15, 2008, 122 Stat. 2506, 2507; Pub. L. 111–148, title III, §§3302(a), 3303(a), 3304(a), 3305, 3309, Mar. 23, 2010, 124 Stat. 468–470, 475; Pub. L. 111–152, title I, §1102(c)(4), Mar. 30, 2010, 124 Stat. 1045; Pub. L. 116–260, div. CC, title I, §118, Dec. 27, 2020, 134 Stat. 2950.)

Editorial Notes

AMENDMENTS

2020—Subsecs. (e), (f). Pub. L. 116–260 added subsec. (e) and redesignated former subsec. (e) as (f).

2010—Subsec. (a)(1)(D)(i). Pub. L. 111–148, §3309, inserted ''or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1315 of this title or subsection (c) or (d) of section 1396n of this title or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1396b(m) of this title or under section 1396u–2 of this title'' after ''1396a(q)(1)(B) of this title)''.

Subsec. (a)(3)(B)(vi). Pub. L. 111–148, §3304(a), added cl. (vi).

Subsec. (a)(5). Pub. L. 111–148, §3303(a), added par. (5).

Subsec. (b)(2)(B)(iii). Pub. L. 111–152 substituted ''and determined before the application of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year involved and, in the case of a qualifying plan, before the application of the increase under section 1395w–23(*o*) of this title for that plan and year involved'' for '', determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1395w–24(b)(1)(C) of this title or bonus payment under section 1395w–23(n) of this title''.

Pub. L. 111–148, § 3302(a), inserted '', determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1395w–23(n) of this title'' before period at end.

Subsecs. (d), (e). Pub. L. 111–148, § 3305, added subsec. (d) and redesignated former subsec. (d) as (e).

2008—Subsec. (a)(1)(A). Pub. L. 110–275, § 114(a)(2), substituted ''equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B).'' for ''equal to—

''(i) 100 percent of the amount described in subsection (b)(1) of this section, but not to exceed the premium amount specified in subsection (b)(2)(B) of this section; plus

''(ii) 80 percent of any late enrollment penalties imposed under section 1395w–113(b) of this title for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month.''

Subsec. (a)(3)(B)(iv)(III). Pub. L. 110–275, § 117(a), added subcl. (III).

Subsec. (a)(3)(C)(i). Pub. L. 110–275, § 116(a)(1), inserted ''and except that support and maintenance furnished in kind shall not be counted as income'' after ''section 1396a(r)(2) of this title''.

Subsec. (a)(3)(D), (E)(i). Pub. L. 110–275, § 116(a)(2), (3), inserted ''subject to the life insurance policy exclusion provided under subparagraph (G)'' after ''program'' in introductory provisions.

Subsec. (a)(3)(G). Pub. L. 110–275, § 116(a)(4), added subpar. (G).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, § 3302(b), Mar. 23, 2010, 124 Stat. 468, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to premiums for months beginning on or after January 1, 2011.''

Amendment by section 3303(a) of Pub. L. 111–148 applicable to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011, see section 3303(c) of Pub. L. 111–148, set out as a note under section 1395w–101 of this title.

Pub. L. 111–148, title III, § 3304(b), Mar. 23, 2010, 124 Stat. 470, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2011.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 114(a)(2) of Pub. L. 110–275 applicable to subsidies for months beginning with Jan. 2009, see section 114(b) of Pub. L. 110–275, set out as a note under section 1395w–113 of this title.

Pub. L. 110–275, title I, § 116(b), July 15, 2008, 122 Stat. 2507, provided that: ''The amendments made by this section [amending this section] shall take effect with respect to applications filed on or after January 1, 2010.''

Pub. L. 110–275, title I, § 117(b), July 15, 2008, 122 Stat. 2507, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173].''

GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR SUBSIDY ELIGIBLE INDIVIDUALS

Pub. L. 108–173, title I, § 107(e), Dec. 8, 2003, 117 Stat. 2171, provided that:

''(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered part D drugs under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] by subsidy eligible individuals differs from such utilization and access for individuals who would qualify as such subsidy eligible individuals but for the application of section 1860D–14(a)(3)(A)(iii) of such Act [42 U.S.C. 1395w–114(a)(3)(A)(iii)].

''(2) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) that includes such recommendations for legislation as the Comptroller General determines are appropriate.''

§ 1395w–114a. Medicare coverage gap discount program

(a) Establishment

The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the ''program'') by not later than January 1, 2011. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than 180 days after March 23, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

(b) Terms of agreement

(1) In general

(A) Agreement

An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

(B) Provision of discounted prices at the point-of-sale

Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

(C) Timing of agreement

(i) Special rule for 2011

In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2011, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than not later than[1] 30 days after the date of the establishment of a model agreement under subsection (a).

(ii) 2012 and subsequent years

In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall

[1] So in original. Second ''not later than'' probably should not appear.

enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

(2) Provision of appropriate data

Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

(3) Compliance with requirements for administration of program

Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

(4) Length of agreement

(A) In general

An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

(ii) By a manufacturer

A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

(iv) Notice to third party

The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

(c) Duties described and special rule for supplemental benefits

(1) Duties described

The duties described in this subsection are the following:

(A) Administration of program

Administering the program, including—

(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

(iii) in the case where, during the period beginning on January 1, 2011, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

(I) the negotiated price of the applicable drug; and

(II) the discounted price of the applicable drug;

(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

(B) Monitoring compliance

(i) In general

The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

(ii) Notification

If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for ap-

propriate enforcement under subsection (e).

(C) Collection of data from prescription drug plans and MA–PD plans

The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

(2) Special rule for supplemental benefits

For plan year 2011 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

(d) Administration

(1) In general

Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

(2) Limitation

(A) In general

Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

(B) Exception

The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on January 1, 2011, and ending on December 31, 2011, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(3) Contract with third parties

The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

(4) Performance requirements

The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

(5) Implementation

The Secretary may implement the program under this section by program instruction or otherwise.

(6) Administration

Chapter 35 of title 44 shall not apply to the program under this section.

(e) Enforcement

(1) Audits

Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

(2) Civil money penalty

(A) In general

The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

(ii) 25 percent of such amount.

(B) Application

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

(f) Clarification regarding availability of other covered part D drugs

Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

(g) Definitions

In this section:

(1) Applicable beneficiary

The term ''applicable beneficiary'' means an individual who, on the date of dispensing a covered part D drug—

(A) is enrolled in a prescription drug plan or an MA–PD plan;

(B) is not enrolled in a qualified retiree prescription drug plan;

(C) is not entitled to an income-related subsidy under section 1395w–114(a) of this title; and

(D) who—

(i) has reached or exceeded the initial coverage limit under section 1395w–102(b)(3) of this title during the year; and

(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(2) Applicable drug

The term ''applicable drug'' means, with respect to an applicable beneficiary, a covered part D drug—

(A) approved under a new drug application under section 355(b) of title 21 or, in the case of a biologic product, licensed under section 262 of this title (other than, with respect to a plan year before 2019, a product licensed under subsection (k) of such section 262); and

(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

(iii) is provided through an exception or appeal.

(3) Applicable number of calendar days

The term ''applicable number of calendar days'' means—

(A) with respect to claims for reimbursement submitted electronically, 14 days; and

(B) with respect to claims for reimbursement submitted otherwise, 30 days.

(4) Discounted price

(A) In general

The term ''discounted price'' means 50 percent (or, with respect to a plan year after plan year 2018, 30 percent) of the negotiated price of the applicable drug of a manufacturer.

(B) Clarification

Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

(C) Special case for certain claims

In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1395w–102(b)(3) of this title and below the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

(5) Manufacturer

The term ''manufacturer'' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Negotiated price

The term ''negotiated price'' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on March 23, 2010), except that such negotiated price shall not include any dispensing fee for the applicable drug.

(7) Qualified retiree prescription drug plan

The term ''qualified retiree prescription drug plan'' has the meaning given such term in section 1395w–132(a)(2) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–14A, as added Pub. L. 111–148, title III, § 3301(b), Mar. 23, 2010, 124 Stat. 462; amended Pub. L. 111–152, title I, § 1101(b)(2), Mar. 30, 2010, 124 Stat. 1037; Pub. L. 115–123, div. E, title XII, §§ 53113, 53116(b), Feb. 9, 2018, 132 Stat. 305, 307.)

Editorial Notes

AMENDMENTS

2018—Subsec. (g)(2)(A). Pub. L. 115–123, § 53113, inserted '', with respect to a plan year before 2019,'' after ''other than''.

Subsec. (g)(4)(A). Pub. L. 115–123, § 53116(b), inserted ''(or, with respect to a plan year after plan year 2018, 30 percent)'' after ''50 percent''.

2010—Subsec. (a). Pub. L. 111–152, § 1101(b)(2)(A), substituted ''January 1, 2011'' for ''July 1, 2010'' and ''180 days after March 23, 2010'' for ''April 1, 2010''.

Subsec. (b)(1)(C)(i). Pub. L. 111–152, § 1101(b)(2)(B)(i), which directed the amendment of subpar. (C) by striking out ''2010 and'' in the heading, was executed by striking ''2010 and'' before ''2011'' in cl. (i) heading to reflect the probable intent of Congress.

Pub. L. 111–152, § 1101(b)(2)(B)(ii), (iii), substituted ''January 1, 2011'' for ''July 1, 2010'' and ''not later than 30 days after the date of the establishment of a model agreement under subsection (a)'' for ''May 1, 2010''.

Subsec. (c)(1)(A)(iii). Pub. L. 111–152, § 1101(b)(2)(C)(i), substituted ''January 1, 2011, and ending on December 31, 2011'' for ''July 1, 2010, and ending on December 31, 2011''.

Subsec. (c)(2). Pub. L. 111–152, § 1101(b)(2)(C)(ii), substituted ''2011'' for ''2010''.

Subsec. (d)(2)(B). Pub. L. 111–152, § 1101(b)(2)(D), substituted ''January 1, 2011, and ending on December 31, 2011'' for ''July 1, 2010, and ending on December 31, 2010''.

Subsec. (g)(1). Pub. L. 111–152, § 1101(b)(2)(E)(i), substituted ''a covered part D drug'' for ''an applicable drug'' in introductory provisions.

Subsec. (g)(1)(C) to (E). Pub. L. 111–152, § 1101(b)(2)(E)(ii)–(iv), inserted ''and'' at end of subpar.

(C), redesignated subpar. (E) as (D), and struck out former subpar. (D) which read as follows: ''is not subject to a reduction in premium subsidy under section 1395r(i) of this title; and''.

§ 1395w–115. Subsidies for part D eligible individuals for qualified prescription drug coverage

(a) Subsidy payment

In order to reduce premium levels applicable to qualified prescription drug coverage for part D eligible individuals consistent with an overall subsidy level of 74.5 percent for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA–PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA–PD plan of the following subsidies in accordance with this section:

(1) Direct subsidy

A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a month equal to—

(A) the amount of the plan's standardized bid amount (as defined in section 1395w–113(a)(5) of this title), adjusted under subsection (c)(1), reduced by

(B) the base beneficiary premium (as computed under paragraph (2) of section 1395w–113(a) of this title and as adjusted under paragraph (1)(B) of such section).

(2) Subsidy through reinsurance

The reinsurance payment amount (as defined in subsection (b)).

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

(b) Reinsurance payment amount

(1) In general

The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a coverage year is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(2) Allowable reinsurance costs

For purposes of this section, the term ''allowable reinsurance costs'' means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

(3) Gross covered prescription drug costs

For purposes of this section, the term ''gross covered prescription drug costs'' means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA–PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

(4) Coverage year defined

For purposes of this section, the term ''coverage year'' means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

(c) Adjustments relating to bids

(1) Health status risk adjustment

(A) Establishment of risk adjustors

The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA–PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) and through that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) and MA monthly prescription drug beneficiary premiums.

(B) Considerations

In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1395w–23(a)(3) of this title to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

(C) Data collection

In order to carry out this paragraph, the Secretary shall require—

(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

(ii) MA organizations that offer MA–PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary

and such other information as the Secretary determines necessary.

(D) Publication

At the time of publication of risk adjustment factors under section 1395w–23(b)(1)(B)(i)(II) of this title, the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

(2) Geographic adjustment

(A) In general

Subject to subparagraph (B), for purposes of section 1395w–113(a)(1)(B)(iii) of this title, the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1395w–113(a)(4) of this title) to take into account differences in prices for covered part D drugs among PDP regions.

(B) De minimis rule

If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

(C) Budget neutral adjustment

Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Secretary had not applied such adjustment.

(d) Payment methods

(1) In general

Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(2) Requirement for provision of information

(A) Requirement

Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

(B) Restriction on use of information

Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(3) Source of payments

Payments under this section shall be made from the Medicare Prescription Drug Account.

(4) Application of enrollee adjustment

The provisions of section 1395w–23(a)(2) of this title shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1395w–23(a) of this title.

(e) Portion of total payments to a sponsor or organization subject to risk (application of risk corridors)

(1) Computation of adjusted allowable risk corridor costs

(A) In general

For purposes of this subsection, the term ''adjusted allowable risk corridor costs'' means, for a plan for a coverage year (as defined in subsection (b)(4))—

(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

(ii) the sum of (I) the total reinsurance payments made under subsection (b) to the sponsor of the plan for the year, and (II) the total subsidy payments made under section 1395w–114 of this title to the sponsor of the plan for the year.

(B) Allowable risk corridor costs

For purposes of this subsection, the term ''allowable risk corridor costs'' means, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic prescription drug coverage taking into account the adjustment under section 1395w–111(c)(2) of this title. In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1395w–114(a) of this title of the maximum amount of copayments permitted under such paragraphs.

(2) Adjustment of payment

(A) No adjustment if adjusted allowable risk corridor costs within risk corridor

If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

(B) Increase in payment if adjusted allowable risk corridor costs above upper limit of risk corridor

(i) Costs between first and second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

(ii) Costs above second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

(iii) Conditions for application of higher percentage for 2006 and 2007

The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

(I) at least 60 percent of prescription drug plans and MA–PD plans to which this subsection applies have adjusted allowable risk corridor costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA–PD plan.

(C) Reduction in payment if adjusted allowable risk corridor costs below lower limit of risk corridor

(i) Costs between first and second threshold lower limits

If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk corridor and such adjusted allowable risk corridor costs.

(ii) Costs below second threshold lower limit

If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

(3) Establishment of risk corridors

(A) In general

For each plan year the Secretary shall establish a risk corridor for each prescription drug plan and each MA–PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

(i) First threshold lower limit

The first threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

(ii) Second threshold lower limit

The second threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

(iii) First threshold upper limit

The first threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (i)(II).

(iv) Second threshold upper limit

The second threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (ii)(II).

(B) Target amount described

The target amount described in this paragraph is, with respect to a prescription drug plan or an MA–PD plan in a year, the total amount of payments paid to the PDP sponsor or MA–PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1395w–113(a)(5) of this title and as risk adjusted under subsection (c)(1)), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

(C) First and second threshold risk percentage defined

(i) First threshold risk percentage

Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

(I) for 2006 and 2007, and[1] 2.5 percent;

(II) for 2008 through 2011, 5 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

(ii) Second threshold risk percentage

Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

(I) for 2006 and 2007, 5 percent;

(II) for 2008 through 2011, 10 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

(iii) Reduction of risk percentage to ensure 2 plans in an area

Pursuant to section 1395w–111(b)(2)(E)(ii) of this title, a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

(4) Plans at risk for entire amount of supplemental prescription drug coverage

A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

(5) No effect on monthly premium

No adjustment in payments made by reason of this subsection shall affect the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

(f) Disclosure of information

(1) In general

Each contract under this part and under part C shall provide that—

(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

(B) the Secretary shall have the right in accordance with section 1395w–27(d)(2)(B) of this title (as applied under section 1395w–112(b)(3)(C) of this title) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

(2) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this section may be used—

(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

(i) carrying out this section; and

(ii) conducting oversight, evaluation, and enforcement under this subchapter;

(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities; and

(C) by the Executive Director of the Medicare Payment Advisory Commission for purposes of monitoring, making recommendations for, and analysis of the program under this subchapter and by the Executive Director of the Medicaid and CHIP Payment and Access Commission for purposes of monitoring, making recommendations for, and analysis of the Medicaid program established under subchapter XIX and the Children's Health Insurance Program under subchapter XXI.

(3) Additional restrictions on disclosure of information

(A) In general

The Executive Directors described in paragraph (2)(C) shall not disclose any of the following information disclosed to such Executive Directors or obtained by such Executive Directors pursuant to such paragraph, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization:

(i) The specific amounts or the identity of the source of any rebates, discounts, price concessions, or other forms of direct or indirect remuneration under such prescription drug plan or such MA–PD plan.

(ii) Information submitted with the bid submitted under section 1395w–111(b) of this title by such PDP sponsor or under section 1395w–24(a) of this title by such MA organization.

(iii) In the case of such information from prescription drug event records, information in a form that would not be permitted under section 423.505(m) of title 42, Code of Federal Regulations, or any successor regulation, if released by the Centers for Medicare & Medicaid Services.

(B) Clarification

The restrictions on disclosures described in subparagraph (A) shall also apply to dis-

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

closures to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission.

(g) Payment for fallback prescription drug plans

In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1395w–111(g)(4) of this title[2]), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1395w–111(g)(5) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–15, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2113; amended Pub. L. 111–148, title VI, § 6402(b)(1), Mar. 23, 2010, 124 Stat. 756; Pub. L. 116–260, div. CC, title I, § 112(a), Dec. 27, 2020, 134 Stat. 2946.)

Editorial Notes

REFERENCES IN TEXT

Section 1395w–111(g)(4) of this title, referred to in subsec. (g), was in the original ''section 1860D–3(c)(4)'', and was translated as reading ''section 1860D–11(g)(4)'', meaning section 1860D–11(g)(4) of the Social Security Act, to reflect the probable intent of Congress, because section 1860D–3, which is classified to section 1395w–103 of this title, does not contain a subsec. (c), and section 1395w–111(g)(4) of this title defines ''fallback prescription drug plan'' for purposes of this part.

AMENDMENTS

2020—Subsec. (f)(2)(C). Pub. L. 116–260, § 112(a)(1), added subpar. (C).

Subsec. (f)(3). Pub. L. 116–260, § 112(a)(2), added par. (3).

2010—Subsec. (f)(2). Pub. L. 111–148 substituted ''may be used—'' for ''may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.'' in introductory provisions and added subpars. (A) and (B).

§ 1395w–116. Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

(a) Establishment and operation of Account

(1) Establishment

There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title an account to be known as the ''Medicare Prescription Drug Account'' (in this section referred to as the ''Account'').

(2) Funding

The Account shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, such Account as provided in this part.

(3) Separate from rest of Trust Fund

Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(b) Payments from Account

(1) In general

The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

(A) payments under section 1395w–114 of this title (relating to low-income subsidy payments);

(B) payments under section 1395w–115 of this title (relating to subsidy payments and payments for fallback plans);

(C) payments to sponsors of qualified retiree prescription drug plans under section 1395w–132(a) of this title; and

(D) payments with respect to administrative expenses under this part in accordance with section 401(g) of this title.

(2) Transfers to Medicaid account for increased administrative costs

The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of section 1396u–5(b) of this title.

(3) Payments of premiums withheld

The Managing Trustee shall make payment to the PDP sponsor or MA organization involved of the premiums (and the portion of late enrollment penalties) that are collected in the manner described in section 1395w–24(d)(2)(A) of this title and that are payable under a prescription drug plan or MA–PD plan offered by such sponsor or organization.

(4) Treatment in relation to part B premium

Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1395r of this title.

(c) Deposits into Account

(1) Low-income transfer

Amounts paid under section 1396u–5(c) of this title (and any amounts collected or offset under paragraph (1)(C) of such section) are deposited into the Account.

(2) Amounts withheld

Pursuant to sections 1395w–113(c) and 1395w–24(d) of this title (as applied under this part), amounts that are withheld (and allocated) to the Account are deposited into the Account.

(3) Appropriations to cover Government contributions

There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b) plus such amounts as the Managing Trustee certifies is necessary to maintain an appropriate contingency margin, reduced by the amounts deposited under paragraph (1) or subsection (a)(2).

[2] See References in Text note below.

(4) Initial funding and reserve

In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

(5) Transfer of any remaining balance from Transitional Assistance Account

Any balance in the Transitional Assistance Account that is transferred under section 1395w–141(k)(5) of this title shall be deposited into the Account.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–16, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2120.)

SUBPART 3—APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND TREATMENT OF EMPLOYER-SPONSORED PROGRAMS AND OTHER PRESCRIPTION DRUG PLANS

§ 1395w–131. Application to Medicare Advantage program and related managed care programs

(a) Special rules relating to offering of qualified prescription drug coverage

(1) In general

An MA organization on and after January 1, 2006—

(A) may not offer an MA plan described in section 1395w–21(a)(2)(A) of this title in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

(i) under an MSA plan; or

(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

(2) Qualifying coverage

For purposes of paragraph (1)(A), the term ''required coverage'' means with respect to an MA–PD plan—

(A) basic prescription drug coverage; or

(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1395w–24(b)(1)(C) of this title).

(b) Application of default enrollment rules

(1) Seamless continuation

In applying section 1395w–21(c)(3)(A)(ii) of this title, an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA–PD plan unless such health benefits plan provides any prescription drug coverage.

(2) MA continuation

In applying section 1395w–21(c)(3)(B) of this title, an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA–PD plan unless—

(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

(B) for periods after January 1, 2006, such MA plan is an MA–PD plan.

(3) Discontinuance of MA–PD election during first year of eligibility

In applying the second sentence of section 1395w–21(e)(4) of this title in the case of an individual who is electing to discontinue enrollment in an MA–PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

(4) Rules regarding enrollees in MA plans not providing qualified prescription drug coverage

In the case of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA–PD plan; and

(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1395ss(s)(3) of this title for purposes of applying such section.

The information disclosed under section 1395w–22(c)(1) of this title for individuals who are enrolled in such an MA plan shall include information regarding such rules.

(c) Application of part D rules for prescription drug coverage

With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

(1) In general

Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA–PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

(2) Waiver

The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions du-

plicate, or are in conflict with, provisions otherwise applicable to the organization or plan under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

(3) Treatment of MA owned and operated pharmacies

The Secretary may waive the requirement of section 1395w–104(b)(1)(C) of this title in the case of an MA–PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

(d) Special rules for private fee-for-service plans that offer prescription drug coverage

With respect to an MA plan described in section 1395w–21(a)(2)(C) of this title that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

(1) Requirements regarding negotiated prices

Subsections (a)(1) and (d)(1) of section 1395w–102 of this title and section 1395w–104(b)(2)(A) of this title shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

(2) Modification of pharmacy access standard and disclosure requirement

If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost-sharing, and without regard to whether they are participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1395w–104 of this title shall not apply to the plan.

(3) Drug utilization management program and medication therapy management program not required

The requirements of subparagraphs (A) and (C) of section 1395w–104(c)(1) of this title shall not apply to the plan.

(4) Application of reinsurance

The Secretary shall determine the amount of reinsurance payments under section 1395w–115(b) of this title using a methodology that—

(A) bases such amount on the Secretary's estimate of the amount of such payments that would be payable if the plan were an MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title and the previous provisions of this subsection did not apply; and

(B) takes into account the average reinsurance payments made under section 1395w–115(b) of this title for populations of similar risk under MA–PD plans described in such section.

(5) Exemption from risk corridor provisions

The provisions of section 1395w–115(e) of this title shall not apply.

(6) Exemption from negotiations

Subsections (d) and (e)(2)(C) of section 1395w–111 of this title shall not apply and the provisions of section 1395w–24(a)(5)(B) of this title prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1395w–111(d) of this title.

(7) Treatment of incurred costs without regard to formulary

The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan's formulary under section 1395w–102(b)(4)(B)(i) of this title shall not apply insofar as the plan does not utilize a formulary.

(e) Application to reasonable cost reimbursement contractors

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1395mm(h) of this title and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395–21(a)(2)(A)(i) of this title and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

(3) Bids not included in determining national average monthly bid amount

The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

(f) Application to PACE

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1395eee of this title that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395w–21(a)(2)(A)(ii) of this title and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

(3) Bids not included in determining standardized bid amount

The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–21, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2122.)

§ 1395w–132. Special rules for employer-sponsored programs

(a) Subsidy payment

(1) In general

The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(2) Qualified retiree prescription drug plan defined

For purposes of this subsection, the term ''qualified retiree prescription drug plan'' means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

(A) Attestation of actuarial equivalence to standard coverage

The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1395w–111(c) of this title) is at least equal to the actuarial value of standard prescription drug coverage, not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(B) Audits

The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1395w–102(d)(3) of this title shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

(C) Provision of disclosure regarding prescription drug coverage

The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1395w–113(b)(6)(B) of this title.

(3) Employer and union special subsidy amounts

(A) In general

For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree's gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

(B) Cost threshold and cost limit applicable

(i) In general

Subject to clause (ii)—

(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(ii) Indexing

The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1395w–102(b) of this title.

(C) Definitions

For purposes of this paragraph:

(i) Allowable retiree costs

The term ''allowable retiree costs'' means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

(ii) Gross covered retiree plan-related prescription drug costs

For purposes of this section, the term ''gross covered retiree plan-related pre-

scription drug costs'' means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

(iii) Coverage year

The term ''coverage year'' has the meaning given such term in section 1395w–115(b)(4) of this title.

(4) Qualifying covered retiree defined

For purposes of this subsection, the term ''qualifying covered retiree'' means a part D eligible individual who is not enrolled in a prescription drug plan or an MA–PD plan but is covered under a qualified retiree prescription drug plan.

(5) Payment methods, including provision of necessary information

The provisions of section 1395w–115(d) of this title (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1395w–115(b) of this title.

(6) Construction

Nothing in this subsection shall be construed as—

(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA–PD plan;

(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA–PD plan on behalf of such an individual;

(C) preventing such employment-based retiree health coverage from providing coverage—

(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA–PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA–PD plan; or

(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

(b) Application of MA waiver authority

The provisions of section 1395w–27(i) of this title shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage.

(c) Definitions

For purposes of this section:

(1) Employment-based retiree health coverage

The term ''employment-based retiree health coverage'' means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

(2) Sponsor

The term ''sponsor'' means a plan sponsor, as defined in section 1002(16)(B) of title 29, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

(3) Group health plan

The term ''group health plan'' includes such a plan as defined in section 1167(1) of title 29 and also includes the following:

(A) Federal and State governmental plans

Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5.

(B) Collectively bargained plans

Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

(C) Church plans

Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–22, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2125; amended Pub. L. 111–152, title I, §1101(b)(4), Mar. 30, 2010, 124 Stat. 1039.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(C), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2010—Subsec. (a)(2)(A). Pub. L. 111–152 inserted before period at end '', not taking into account the value of

any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title''.

Statutory Notes and Related Subsidiaries

STUDY ON EMPLOYMENT-BASED RETIREE HEALTH COVERAGE

Pub. L. 108–173, title I, § 111, Dec. 8, 2003, 117 Stat. 2174, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct an initial and final study under this subsection [probably should be this section] to examine trends in employment-based retiree health coverage (as defined in [sic] 1860D–22(c)(1) of the Social Security Act [42 U.S.C. 1395w–132(c)(1)], as added by section 101), including coverage under the Federal Employees Health Benefits Program (FEHBP), and the options and incentives available under this Act [see Tables for classification] which may have an effect on the voluntary provision of such coverage.

''(b) CONTENT OF INITIAL STUDY.—The initial study under this section shall consider the following:

''(1) Trends in employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003].

''(2) The opinions of sponsors of employment-based retiree health coverage concerning which of the options available under this Act [see Tables for classification] they are most likely to utilize for the provision of health coverage to their medicare-eligible retirees, including an assessment of the administrative burdens associated with the available options.

''(3) The likelihood of sponsors of employment-based retiree health coverage to maintain or adjust their levels of retiree health benefits beyond coordination with medicare, including for prescription drug coverage, provided to medicare-eligible retirees after the date of the enactment of this Act.

''(4) The factors that sponsors of employment-based retiree health coverage expect to consider in making decisions about any changes they may make in the health coverage provided to medicare-eligible retirees.

''(5) Whether the prescription drug plan options available, or the health plan options available under the Medicare Advantage program, are likely to cause employers and other entities that did not provide health coverage to retirees prior to the date of the enactment of this Act to provide supplemental coverage or contributions toward premium expenses for medicare-eligible retirees who may enroll in such options in the future.

''(c) CONTENTS OF FINAL STUDY.—The final study under this section shall consider the following:

''(1) Changes in the trends in employment-based retiree health coverage since the completion of the initial study by the Comptroller General.

''(2) Factors contributing to any changes in coverage levels.

''(3) The number and characteristics of sponsors of employment-based retiree health coverage who receive the special subsidy payments under section 1860D–22 of the Social Security Act [42 U.S.C. 1395w–132], as added by section 101, for the provision of prescription drug coverage to their medicare-eligible retirees that is the same or greater actuarial value as the prescription drug coverage available to other medicare beneficiaries without employment-based retiree health coverage.

''(4) The extent to which sponsors of employment-based retiree health coverage provide supplemental health coverage or contribute to the premiums for medicare-eligible retirees who enroll in a prescription drug plan or an MA–PD plan.

''(5) Other coverage options, including tax-preferred retirement or health savings accounts, consumer-directed health plans, or other vehicles that sponsors of employment-based retiree health coverage believe would assist retirees with their future health care needs and their willingness to sponsor such alternative plan designs.

''(6) The extent to which employers or other entities that did not provide employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003] provided some form of coverage or financial assistance for retiree health care needs after the date of the enactment of this Act.

''(7) Recommendations by employers, benefits experts, academics, and others on ways that the voluntary provision of employment-based retiree health coverage may be improved and expanded.

''(d) REPORTS.—The Comptroller General shall submit a report to Congress on—

''(1) the initial study under subsection (b) not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]; and

''(2) the final study under subsection (c) not later than January 1, 2007.

''(e) CONSULTATION.—The Comptroller General shall consult with sponsors of employment-based retiree health coverage, benefits experts, human resources professionals, employee benefits consultants, and academics with experience in health benefits and survey research in the development and design of the initial and final studies under this section.''

§ 1395w–133. State Pharmaceutical Assistance Programs

(a) Requirements for benefit coordination

(1) In general

Before July 1, 2005, the Secretary shall establish consistent with this section requirements for prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

(A) payment of premiums and coverage; and

(B) payment for supplemental prescription drug benefits,

for part D eligible individuals enrolled under both types of plans.

(2) Coordination elements

The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

(A) Enrollment file sharing.

(B) The processing of claims, including electronic processing.

(C) Claims payment.

(D) Claims reconciliation reports.

(E) Application of the protection against high out-of-pocket expenditures under section 1395w–102(b)(4) of this title.

(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

(3) Use of lump sum per capita method

Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

(4) Consultation

In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

(5) Part D plan defined

For purposes of this section and section 1395w–134 of this title, the term ''part D plan'' means a prescription drug plan and an MA–PD plan.

(b) State Pharmaceutical Assistance Program

For purposes of this part, the term ''State Pharmaceutical Assistance Program'' means a State program—

(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

(3) which satisfies the requirements of subsections (a) and (c).

(c) Relation to other provisions

(1) Medicare as primary payor

The requirements of this section shall not change or affect the primary payor status of a part D plan.

(2) Use of a single card

A card that is issued under section 1395w–104(b)(2)(A) of this title for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such connection.

(3) Other provisions

The provisions of section 1395w–134(c) of this title shall apply to the requirements under this section.

(4) Special treatment under out-of-pocket rule

In applying section 1395w–102(b)(4)(C)(ii) of this title, expenses incurred under a State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

(5) Construction

Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

(d) Facilitation of transition and coordination with State Pharmaceutical Assistance Programs

(1) Transitional grant program

The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

(2) Use of funds

Payments under this section may be used by a Program for any of the following:

(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

(3) Allocation of funds

Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.

(4) Application

No payments may be made under this subsection except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary.

(5) Funding

Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2005 and 2006, $62,500,000 to carry out this subsection.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–23, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2128.)

§1395w–134. Coordination requirements for plans providing prescription drug coverage

(a) Application of benefit coordination requirements to additional plans

(1) In general

The Secretary shall apply the coordination requirements established under section 1395w–133(a) of this title to Rx plans described in subsection (b) in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

(2) Application to treatment of certain out-of-pocket expenditures

To the extent specified by the Secretary, the requirements referred to in paragraph (1) shall apply to procedures established under section 1395w–102(b)(4)(D) of this title.

(3) User fees

(A) In general

The Secretary may impose user fees for the transmittal of information necessary for benefit coordination under section 1395w–102(b)(4)(D) of this title in a manner similar to the manner in which user fees are imposed under section 1395u(h)(3)(B) of this title, except that the Secretary may retain a portion of such fees to defray the Secretary's costs in carrying out procedures under section 1395w–102(b)(4)(D) of this title.

(B) Application

A user fee may not be imposed under subparagraph (A) with respect to a State Pharmaceutical Assistance Program.

(b) Rx Plan

An Rx plan described in this subsection is any of the following:

(1) Medicaid programs

A State plan under subchapter XIX, including such a plan operating under a waiver under section 1315 of this title, if it meets the requirements of section 1395w–133(b)(2) of this title.

(2) Group health plans

An employer group health plan.

(3) FEHBP

The Federal employees health benefits plan under chapter 89 of title 5.

(4) Military coverage (including TRICARE)

Coverage under chapter 55 of title 10.

(5) Other prescription drug coverage

Such other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of part D eligible individuals as the Secretary may specify.

(c) Relation to other provisions

(1) Use of cost management tools

The requirements of this section shall not impair or prevent a PDP sponsor or MA organization from applying cost management tools (including differential payments) under all methods of operation.

(2) No affect[1] on treatment of certain out-of-pocket expenditures

The requirements of this section shall not affect the application of the procedures established under section 1395w–102(b)(4)(D) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–24, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2130.)

SUBPART 4—MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM

§ 1395w–141. Medicare prescription drug discount card and transitional assistance program

(a) Establishment of program

(1) In general

The Secretary shall establish a program under this section—

(A) to endorse prescription drug discount card programs that meet the requirements of this section in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States; and

(B) to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs.

(2) Period of operation

(A) Implementation deadline

The Secretary shall implement the program under this section so that discount cards and transitional assistance are first available by not later than 6 months after December 8, 2003.

(B) Expediting implementation

The Secretary shall promulgate regulations to carry out the program under this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

(C) Termination and transition

(i) In general

Subject to clause (ii)—

(I) the program under this section shall not apply to covered discount card drugs dispensed after December 31, 2005; and

(II) transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

(ii) Transition

In the case of an individual who is enrolled in an endorsed discount card program as of December 31, 2005, during the individual's transition period (if any) under clause (iii), in accordance with transition rules specified by the Secretary—

(I) such endorsed program may continue to apply to covered discount card drugs dispensed to the individual under the program during such transition period;

(II) no annual enrollment fee shall be applicable during the transition period;

(III) during such period the individual may not change the endorsed program plan in which the individual is enrolled; and

(IV) the balance of any transitional assistance remaining on January 1, 2006, shall remain available for drugs dispensed during the individual's transition period.

(iii) Transition period

The transition period under this clause for an individual is the period beginning on January 1, 2006, and ending in the case of an individual who—

(I) is enrolled in a prescription drug plan or an MA–PD plan before the last date of the initial enrollment period under section 1395w–101(b)(2)(A) of this title, on the effective date of the individual's coverage under such part; or

(II) is not so enrolled, on the last day of such initial period.

(3) Voluntary nature of program

Nothing in this section shall be construed as requiring a discount card eligible individual to

[1] So in original. Probably should be ''effect''.

enroll in an endorsed discount card program under this section.

(4) Glossary and definitions of terms

For purposes of this section:

(A) Covered discount card drug

The term ''covered discount card drug'' has the meaning given the term ''covered part D drug'' in section 1395w–102(e) of this title.

(B) Discount card eligible individual

The term ''discount card eligible individual'' is defined in subsection (b)(1)(A).

(C) Endorsed discount card program; endorsed program

The terms ''endorsed discount card program'' and ''endorsed program'' mean a prescription drug discount card program that is endorsed (and for which the sponsor has a contract with the Secretary) under this section.

(D) Negotiated price

Negotiated prices are described in subsection (e)(1)(A)(ii).

(E) Prescription drug card sponsor; sponsor

The terms ''prescription drug card sponsor'' and ''sponsor'' are defined in subsection (h)(1)(A).

(F) State

The term ''State'' has the meaning given such term for purposes of subchapter XIX.

(G) Transitional assistance eligible individual

The term ''transitional assistance eligible individual'' is defined in subsection (b)(2).

(b) Eligibility for discount card and for transitional assistance

For purposes of this section:

(1) Discount card eligible individual

(A) In general

The term ''discount card eligible individual'' means an individual who—

(i) is entitled to benefits, or enrolled, under part A or enrolled under part B; and

(ii) subject to paragraph (4), is not an individual described in subparagraph (B).

(B) Individual described

An individual described in this subparagraph is an individual described in subparagraph (A)(i) who is enrolled under subchapter XIX (or under a waiver under section 1315 of this title of the requirements of such subchapter) and is entitled to any medical assistance for outpatient prescribed drugs described in section 1396d(a)(12) of this title.

(2) Transitional assistance eligible individual

(A) In general

Subject to subparagraph (B), the term ''transitional assistance eligible individual'' means a discount card eligible individual who resides in one of the 50 States or the District of Columbia and whose income (as determined under subsection (f)(1)(B)) is not more than 135 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(B) Exclusion of individuals with certain prescription drug coverage

Such term does not include an individual who has coverage of, or assistance for, covered discount card drugs under any of the following:

(i) A group health plan or health insurance coverage (as such terms are defined in section 300gg–91 of this title), other than coverage under a plan under part C and other than coverage consisting only of excepted benefits (as defined in such section).

(ii) Chapter 55 of title 10 (relating to medical and dental care for members of the uniformed services).

(iii) A plan under chapter 89 of title 5 (relating to the Federal employees' health benefits program).

(3) Special transitional assistance eligible individual

The term ''special transitional assistance eligible individual'' means a transitional assistance eligible individual whose income (as determined under subsection (f)(1)(B)) is not more than 100 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(4) Treatment of medicaid medically needy

For purposes of this section, the Secretary shall provide for appropriate rules for the treatment of medically needy individuals described in section 1396a(a)(10)(C) of this title as discount card eligible individuals and as transitional assistance eligible individuals.

(c) Enrollment and enrollment fees

(1) Enrollment process

The Secretary shall establish a process through which a discount card eligible individual is enrolled and disenrolled in an endorsed discount card program under this section consistent with the following:

(A) Continuous open enrollment

Subject to the succeeding provisions of this paragraph and subsection (h)(9), a discount card eligible individual who is not enrolled in an endorsed discount card program and is residing in a State may enroll in any such endorsed program—

(i) that serves residents of the State; and

(ii) at any time beginning on the initial enrollment date, specified by the Secretary, and before January 1, 2006.

(B) Use of standard enrollment form

An enrollment in an endorsed program shall only be effected through completion of a standard enrollment form specified by the Secretary. Each sponsor of an endorsed program shall transmit to the Secretary (in a

form and manner specified by the Secretary) information on individuals who complete such enrollment forms and, to the extent provided under subsection (f), information regarding certification as a transitional assistance eligible individual.

(C) Enrollment only in one program

(i) In general

Subject to clauses (ii) and (iii), a discount card eligible individual may be enrolled in only one endorsed discount card program under this section.

(ii) Change in endorsed program permitted for 2005

The Secretary shall establish a process, similar to (and coordinated with) the process for annual, coordinated elections under section 1395w–21(e)(3) of this title during 2004, under which an individual enrolled in an endorsed discount card program may change the endorsed program in which the individual is enrolled for 2005.

(iii) Additional exceptions

The Secretary shall permit an individual to change the endorsed discount card program in which the individual is enrolled in the case of an individual who changes residence to be outside the service area of such program and in such other exceptional cases as the Secretary may provide (taking into account the circumstances for special election periods under section 1395w–21(e)(4) of this title). Under the previous sentence, the Secretary may consider a change in residential setting (such as placement in a nursing facility) or enrollment in or disenrollment from a plan under part C through which the individual was enrolled in an endorsed program to be an exceptional circumstance.

(D) Disenrollment

(i) Voluntary

An individual may voluntarily disenroll from an endorsed discount card program at any time. In the case of such a voluntary disenrollment, the individual may not enroll in another endorsed program, except under such exceptional circumstances as the Secretary may recognize under subparagraph (C)(iii) or during the annual coordinated enrollment period provided under subparagraph (C)(ii).

(ii) Involuntary

An individual who is enrolled in an endorsed discount card program and not a transitional assistance eligible individual may be disenrolled by the sponsor of the program if the individual fails to pay any annual enrollment fee required under the program.

(E) Application to certain enrollees

In the case of a discount card eligible individual who is enrolled in a plan described in section 1395w–21(a)(2)(A) of this title or under a reasonable cost reimbursement contract under section 1395mm(h) of this title that is offered by an organization that also is a prescription discount card sponsor that offers an endorsed discount card program under which the individual may be enrolled and that has made an election to apply the special rules under subsection (h)(9)(B) for such an endorsed program, the individual may only enroll in such an endorsed discount card program offered by that sponsor.

(2) Enrollment fees

(A) In general

Subject to the succeeding provisions of this paragraph, a prescription drug card sponsor may charge an annual enrollment fee for each discount card eligible individual enrolled in an endorsed discount card program offered by such sponsor. The annual enrollment fee for either 2004 or 2005 shall not be prorated for portions of a year. There shall be no annual enrollment fee for a year after 2005.

(B) Amount

No annual enrollment fee charged under subparagraph (A) may exceed $30.

(C) Uniform enrollment fee

A prescription drug card sponsor shall ensure that the annual enrollment fee (if any) for an endorsed discount card program is the same for all discount card eligible individuals enrolled in the program and residing in the State.

(D) Collection

The annual enrollment fee (if any) charged for enrollment in an endorsed program shall be collected by the sponsor of the program.

(E) Payment of fee for transitional assistance eligible individuals

Under subsection (g)(1)(A), the annual enrollment fee (if any) otherwise charged under this paragraph with respect to a transitional assistance eligible individual shall be paid by the Secretary on behalf of such individual.

(F) Optional payment of fee by State

(i) In general

The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State to the sponsor.

(ii) No Federal matching available under medicaid or SCHIP

Expenditures made by a State for enrollment fees described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under subchapter XIX or XXI.

(G) Rules in case of changes in program enrollment during a year

The Secretary shall provide special rules in the case of payment of an annual enroll-

ment fee for a discount card eligible individual who changes the endorsed program in which the individual is enrolled during a year.

(3) Issuance of discount card

Each prescription drug card sponsor of an endorsed discount card program shall issue, in a standard format specified by the Secretary, to each discount card eligible individual enrolled in such program a card that establishes proof of enrollment and that can be used in a coordinated manner to identify the sponsor, program, and individual for purposes of the program under this section.

(4) Period of access

In the case of a discount card eligible individual who enrolls in an endorsed program, access to negotiated prices and transitional assistance, if any, under such endorsed program shall take effect on such date as the Secretary shall specify.

(d) Provision of information on enrollment and program features

(1) Secretarial responsibilities

(A) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to discount card eligible individuals (and prospective eligible individuals) regarding—

(i) enrollment in endorsed discount card programs; and

(ii) the features of the program under this section, including the availability of transitional assistance.

(B) Promotion of informed choice

In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which—

(i) compares the annual enrollment fee and other features of such programs, which may include comparative prices for covered discount card drugs; and

(ii) includes educational materials on the variability of discounts on prices of covered discount card drugs under an endorsed program.

The dissemination of information under clause (i) shall, to the extent practicable, be coordinated with the dissemination of educational information on other medicare options.

(C) Special rule for initial enrollment date under the program

To the extent practicable, the Secretary shall ensure, through the activities described in subparagraphs (A) and (B), that discount card eligible individuals are provided with such information at least 30 days prior to the initial enrollment date specified under subsection (c)(1)(A)(ii).

(D) Use of medicare toll-free number

The Secretary shall provide through the toll-free telephone number 1–800–MEDICARE for the receipt and response to inquiries and complaints concerning the program under this section and endorsed programs.

(2) Prescription drug card sponsor responsibilities

(A) In general

Each prescription drug card sponsor that offers an endorsed discount card program shall make available to discount card eligible individuals (through the Internet and otherwise) information that the Secretary identifies as being necessary to promote informed choice among endorsed discount card programs by such individuals, including information on enrollment fees and negotiated prices for covered discount card drugs charged to such individuals.

(B) Response to enrollee questions

Each sponsor offering an endorsed discount card program shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices and the amount of transitional assistance remaining available through the program) to discount card eligible individuals enrolled in the program. The sponsor shall inform transitional assistance eligible individuals enrolled in the program of the availability of such toll-free telephone number to provide information on the amount of available transitional assistance.

(C) Information on balance of transitional assistance available at point-of-sale

Each sponsor offering an endorsed discount card program shall have a mechanism so that information on the amount of transitional assistance remaining under subsection (g)(1)(B) is available (electronically or by telephone) at the point-of-sale of covered discount card drugs.

(3) Public disclosure of pharmaceutical prices for equivalent drugs

(A) In general

A prescription drug card sponsor offering an endorsed discount card program shall provide that each pharmacy that dispenses a covered discount card drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(B) Timing of notice

(i) In general

Subject to clause (ii), the information under subparagraph (A) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(ii) Waiver

The Secretary may waive clause (i) in such circumstances as the Secretary may specify.

(e) Discount card features

(1) Savings to enrollees through negotiated prices

(A) Access to negotiated prices

(i) In general

Each prescription drug card sponsor that offers an endorsed discount card program shall provide each discount card eligible individual enrolled in the program with access to negotiated prices.

(ii) Negotiated prices

For purposes of this section, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered discount card drugs, and include any dispensing fees for such drugs.

(B) Ensuring pharmacy access

Each prescription drug card sponsor offering an endorsed discount card program shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than solely by mail order) drugs directly to enrollees to ensure convenient access to covered discount card drugs at negotiated prices (consistent with rules established by the Secretary). The Secretary shall establish convenient access rules under this clause that are no less favorable to enrollees than the standards for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(C) Prohibition on charges for required services

(i) In general

Subject to clause (ii), a prescription drug card sponsor (and any pharmacy contracting with such sponsor for the provision of covered discount card drugs to individuals enrolled in such sponsor's endorsed discount card program) may not charge an enrollee any amount for any items and services required to be provided by the sponsor under this section.

(ii) Construction

Nothing in clause (i) shall be construed to prevent—

(I) the sponsor from charging the annual enrollment fee (except in the case of a transitional assistance eligible individual); and

(II) the pharmacy dispensing the covered discount card drug, from imposing a charge (consistent with the negotiated price) for the covered discount card drug dispensed, reduced by the amount of any transitional assistance made available.

(D) Inapplicability of medicaid best price rules

The prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1396r–8(c)(1)(C) of this title.

(2) Reduction of medication errors and adverse drug interactions

Each endorsed discount card program shall implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

(f) Eligibility procedures for endorsed programs and transitional assistance

(1) Determinations

(A) Procedures

The determination of whether an individual is a discount card eligible individual or a transitional assistance eligible individual or a special transitional assistance eligible individual (as defined in subsection (b)) shall be determined under procedures specified by the Secretary consistent with this subsection.

(B) Income and family size determinations

For purposes of this section, the Secretary shall define the terms ''income'' and ''family size'' and shall specify the methods and period for which they are determined. If under such methods income or family size is determined based on the income or family size for prior periods of time, the Secretary shall permit (whether through a process of reconsideration or otherwise) an individual whose income or family size has changed to elect to have eligibility for transitional assistance determined based on income or family size for a more recent period.

(2) Use of self-certification for transitional assistance

(A) In general

Under the procedures specified under paragraph (1)(A) an individual who wishes to be treated as a transitional assistance eligible individual or a special transitional assistance eligible individual under this section (or another qualified person on such individual's behalf) shall certify on the enrollment form under subsection (c)(1)(B) (or similar form specified by the Secretary), through a simplified means specified by the Secretary and under penalty of perjury or similar sanction for false statements, as to the amount of the individual's income, family size, and individual's prescription drug coverage (if any) insofar as they relate to eligibility to be a transitional assistance eligible individual or a special transitional assistance eligible individual. Such certification shall be deemed as consent to verification of respective eligibility under paragraph (3). A certification under this paragraph may be provided before, on, or after the time of enrollment under an endorsed program.

(B) Treatment of self-certification

The Secretary shall treat a certification under subparagraph (A) that is verified under paragraph (3) as a determination that

the individual involved is a transitional assistance eligible individual or special transitional assistance eligible individual (as the case may be) for the entire period of the enrollment of the individual in any endorsed program.

(3) Verification

(A) In general

The Secretary shall establish methods (which may include the use of sampling and the use of information described in subparagraph (B)) to verify eligibility for individuals who seek to enroll in an endorsed program and for individuals who provide a certification under paragraph (2).

(B) Information described

The information described in this subparagraph is as follows:

(i) Medicaid-related information

Information on eligibility under subchapter XIX and provided to the Secretary under arrangements between the Secretary and States in order to verify the eligibility of individuals who seek to enroll in an endorsed program and of individuals who provide certification under paragraph (2).

(ii) Social security information

Financial information made available to the Secretary under arrangements between the Secretary and the Commissioner of Social Security in order to verify the eligibility of individuals who provide such certification.

(iii) Information from Secretary of the Treasury

Financial information made available to the Secretary under section 6103(*l*)(19) of the Internal Revenue Code of 1986 in order to verify the eligibility of individuals who provide such certification.

(C) Verification in cases of medicaid enrollees

(i) In general

Nothing in this section shall be construed as preventing the Secretary from finding that a discount card eligible individual meets the income requirements under subsection (b)(2)(A) if the individual is within a category of discount card eligible individuals who are enrolled under subchapter XIX (such as qualified medicare beneficiaries (QMBs), specified low-income medicare beneficiaries (SLMBs), and certain qualified individuals (QI–1s)).

(ii) Availability of information for verification purposes

As a condition of provision of Federal financial participation to a State that is one of the 50 States or the District of Columbia under subchapter XIX, for purposes of carrying out this section, the State shall provide the information it submits to the Secretary relating to such subchapter in a manner specified by the Secretary that permits the Secretary to identify individuals who are described in subsection (b)(1)(B) or are transitional assistance eligible individuals or special transitional assistance eligible individuals.

(4) Reconsideration

(A) In general

The Secretary shall establish a process under which a discount card eligible individual, who is determined through the certification and verification methods under paragraphs (2) and (3) not to be a transitional assistance eligible individual or a special transitional assistance eligible individual, may request a reconsideration of the determination.

(B) Contract authority

The Secretary may enter into a contract to perform the reconsiderations requested under subparagraph (A).

(C) Communication of results

Under the process under subparagraph (A) the results of such reconsideration shall be communicated to the individual and the prescription drug card sponsor involved.

(g) Transitional assistance

(1) Provision of transitional assistance

An individual who is a transitional assistance eligible individual (as determined under this section) and who is enrolled with an endorsed program is entitled—

(A) to have payment made of any annual enrollment fee charged under subsection (c)(2) for enrollment under the program; and

(B) to have payment made, up to the amount specified in paragraph (2), under such endorsed program of 90 percent (or 95 percent in the case of a special transitional assistance eligible individual) of the costs incurred for covered discount card drugs obtained through the program taking into account the negotiated price (if any) for the drug under the program.

(2) Limitation on dollar amount

(A) In general

Subject to subparagraph (B), the amount specified in this paragraph for a transitional assistance eligible individual—

(i) for costs incurred during 2004, is $600; or

(ii) for costs incurred during 2005, is—

(I) $600, plus

(II) except as provided in subparagraph (E), the amount by which the amount available under this paragraph for 2004 for that individual exceeds the amount of payment made under paragraph (1)(B) for that individual for costs incurred during 2004.

(B) Proration

(i) In general

In the case of an individual not described in clause (ii) with respect to a year, the Secretary may prorate the amount specified in subparagraph (A) for the balance of the year involved in a manner specified by the Secretary.

(ii) Individual described

An individual described in this clause is a transitional assistance eligible individual who—

(I) with respect to 2004, enrolls in an endorsed program, and provides a certification under subsection (f)(2), before the initial implementation date of the program under this section; and

(II) with respect to 2005, is enrolled in an endorsed program, and has provided such a certification, before February 1, 2005.

(C) Accounting for available balances in cases of changes in program enrollment

In the case of a transitional assistance eligible individual who changes the endorsed discount card program in which the individual is enrolled under this section, the Secretary shall provide a process under which the Secretary provides to the sponsor of the endorsed program in which the individual enrolls information concerning the balance of amounts available on behalf of the individual under this paragraph.

(D) Limitation on use of funds

Pursuant to subsection (a)(2)(C), no assistance shall be provided under paragraph (1)(B) with respect to covered discount card drugs dispensed after December 31, 2005.

(E) No rollover permitted in case of voluntary disenrollment

Except in such exceptional cases as the Secretary may provide, in the case of a transitional assistance eligible individual who voluntarily disenrolls from an endorsed plan, the provisions of subclause (II) of subparagraph (A)(ii) shall not apply.

(3) Payment

The Secretary shall provide a method for the reimbursement of prescription drug card sponsors for assistance provided under this subsection.

(4) Coverage of coinsurance

(A) Waiver permitted by pharmacy

Nothing in this section shall be construed as precluding a pharmacy from reducing or waiving the application of coinsurance imposed under paragraph (1)(B) in accordance with section 1320a–7b(b)(3)(G) of this title.

(B) Optional payment of coinsurance by State

(i) In general

The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the coinsurance under paragraph (1)(B) for some or all enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the coinsurance shall be paid directly by the State to the pharmacy involved.

(ii) No Federal matching available under medicaid or SCHIP

Expenditures made by a State for coinsurance described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under subchapter XIX or XXI.

(iii) Not treated as medicare cost-sharing

Coinsurance described in paragraph (1)(B) shall not be treated as coinsurance under this subchapter for purposes of section 1396d(p)(3)(B) of this title.

(C) Treatment of coinsurance

The amount of any coinsurance imposed under paragraph (1)(B), whether paid or waived under this paragraph, shall not be taken into account in applying the limitation in dollar amount under paragraph (2).

(5) Ensuring access to transitional assistance for qualified residents of long-term care facilities and American Indians

(A) Residents of long-term care facilities

The Secretary shall establish procedures and may waive requirements of this section as necessary to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities in order to ensure access to transitional assistance for transitional assistance eligible individuals who reside in long-term care facilities.

(B) American Indians

The Secretary shall establish procedures and may waive requirements of this section to ensure that, for purposes of providing transitional assistance, pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 1603 of title 25) have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and the District of Columbia where such a pharmacy operates.

(6) No impact on benefits under other programs

The availability of negotiated prices or transitional assistance under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.

(7) Disregard for purposes of part C

Nonuniformity of benefits resulting from the implementation of this section (including the provision or nonprovision of transitional assistance and the payment or waiver of any enrollment fee under this section) shall not be taken into account in applying section 1395w–24(f) of this title.

(h) Qualification of prescription drug card sponsors and endorsement of discount card programs; beneficiary protections

(1) Prescription drug card sponsor and qualifications

(A) Prescription drug card sponsor and sponsor defined

For purposes of this section, the terms ''prescription drug card sponsor'' and ''spon-

sor'' mean any nongovernmental entity that the Secretary determines to be appropriate to offer an endorsed discount card program under this section, which may include—

(i) a pharmaceutical benefit management company;

(ii) a wholesale or retail pharmacy delivery system;

(iii) an insurer (including an insurer that offers medicare supplemental policies under section 1395ss of this title);

(iv) an organization offering a plan under part C; or

(v) any combination of the entities described in clauses (i) through (iv).

(B) Administrative qualifications

Each endorsed discount card program shall be operated directly, or through arrangements with an affiliated organization (or organizations), by one or more entities that have demonstrated experience and expertise in operating such a program or a similar program and that meets such business stability and integrity requirements as the Secretary may specify.

(C) Accounting for transitional assistance

The sponsor of an endorsed discount card program shall have arrangements satisfactory to the Secretary to account for the assistance provided under subsection (g) on behalf of transitional assistance eligible individuals.

(2) Applications for program endorsement

(A) Submission

Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, an application containing such information as the Secretary may require.

(B) Approval; compliance with applicable requirements

The Secretary shall review the application submitted under subparagraph (A) and shall determine whether to endorse the prescription drug discount card program. The Secretary may not endorse such a program unless—

(i) the program and prescription drug card sponsor offering the program comply with the applicable requirements under this section; and

(ii) the sponsor has entered into a contract with the Secretary to carry out such requirements.

(C) Termination of endorsement and contracts

An endorsement of an endorsed program and a contract under subparagraph (B) shall be for the duration of the program under this section (including any transition applicable under subsection (a)(2)(C)(ii)), except that the Secretary may, with notice and for cause (as defined by the Secretary), terminate such endorsement and contract.

(D) Ensuring choice of programs

(i) In general

The Secretary shall ensure that there is available to each discount card eligible individual a choice of at least 2 endorsed programs (each offered by a different sponsor).

(ii) Limitation on number

The Secretary may limit (but not below 2) the number of sponsors in a State that are awarded contracts under this paragraph.

(3) Service area encompassing entire States

Except as provided in paragraph (9), if a prescription drug card sponsor that offers an endorsed program enrolls in the program individuals residing in any part of a State, the sponsor must permit any discount card eligible individual residing in any portion of the State to enroll in the program.

(4) Savings to medicare beneficiaries

Each prescription drug card sponsor that offers an endorsed discount card program shall pass on to discount card eligible individuals enrolled in the program negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers, to the extent disclosed under subsection (i)(1).

(5) Grievance mechanism

Each prescription drug card sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor carries out the endorsed discount card program) and enrollees in endorsed discount card programs of the sponsor under this section in a manner similar to that required under section 1395w–22(f) of this title.

(6) Confidentiality of enrollee records

(A) In general

For purposes of the program under this section, the operations of an endorsed program are covered functions and a prescription drug card sponsor is a covered entity for purposes of applying part C of subchapter XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).[1]

(B) Waiver authority

In order to promote participation of sponsors in the program under this section, the Secretary may waive such relevant portions of regulations relating to privacy referred to in subparagraph (A), for such appropriate, limited period of time, as the Secretary specifies.

(7) Limitation on provision and marketing of products and services

The sponsor of an endorsed discount card program—

[1] See References in Text note below.

(A) may provide under the program—

(i) a product or service only if the product or service is directly related to a covered discount card drug; or

(ii) a discount price for nonprescription drugs; and

(B) may, to the extent otherwise permitted under paragraph (6) (relating to application of HIPAA requirements), market a product or service under the program only if the product or service is directly related to—

(i) a covered discount card drug; or

(ii) a drug described in subparagraph (A)(ii) and the marketing consists of information on the discounted price made available for the drug involved.

(8) Additional protections

Each endorsed discount card program shall meet such additional requirements as the Secretary identifies to protect and promote the interest of discount card eligible individuals, including requirements that ensure that discount card eligible individuals enrolled in endorsed discount card programs are not charged more than the lower of the price based on negotiated prices or the usual and customary price.

(9) Special rules for certain organizations

(A) In general

In the case of an organization that is offering a plan under part C or enrollment under a reasonable cost reimbursement contract under section 1395mm(h) of this title that is seeking to be a prescription drug card sponsor under this section, the organization may elect to apply the special rules under subparagraph (B) with respect to enrollees in any plan described in section 1395w–21(a)(2)(A) of this title that it offers or under such contract and an endorsed discount card program it offers, but only if it limits enrollment under such program to individuals enrolled in such plan or under such contract.

(B) Special rules

The special rules under this subparagraph are as follows:

(i) Limitation on enrollment

The sponsor limits enrollment under this section under the endorsed discount card program to discount card eligible individuals who are enrolled in the part C plan involved or under the reasonable cost reimbursement contract involved and is not required nor permitted to enroll other individuals under such program.

(ii) Pharmacy access

Pharmacy access requirements under subsection (e)(1)(B) are deemed to be met if the access is made available through a pharmacy network (and not only through mail order) and the network used by the sponsor is approved by the Secretary.

(iii) Sponsor requirements

The Secretary may waive the application of such requirements for a sponsor as the Secretary determines to be duplicative or to conflict with a requirement of the organization under part C or section 1395mm of this title (as the case may be) or to be necessary in order to improve coordination of this section with the benefits under such part or section.

(i) Disclosure and oversight

(1) Disclosure

Each prescription drug card sponsor offering an endorsed discount card program shall disclose to the Secretary (in a manner specified by the Secretary) information relating to program performance, use of prescription drugs by discount card eligible individuals enrolled in the program, the extent to which negotiated price concessions described in subsection (e)(1)(A)(ii) made available to the entity by a manufacturer are passed through to enrollees through pharmacies or otherwise, and such other information as the Secretary may specify. The provisions of section 1396r–8(b)(3)(D) of this title shall apply to drug pricing data reported under the previous sentence (other than data in aggregate form).

(2) Oversight; audit and inspection authority

The Secretary shall provide appropriate oversight to ensure compliance of endorsed discount card programs and their sponsors with the requirements of this section. The Secretary shall have the right to audit and inspect any books and records of a prescription discount card sponsor (and of any affiliated organization referred to in subsection (h)(1)(B)) that pertain to the endorsed discount card program under this section, including amounts payable to the sponsor under this section.

(3) Sanctions for abusive practices

The Secretary may implement intermediate sanctions or may revoke the endorsement of a program offered by a sponsor under this section if the Secretary determines that the sponsor or the program no longer meets the applicable requirements of this section or that the sponsor has engaged in false or misleading marketing practices. The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for conduct that a party knows or should know is a violation of this section. The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(j) Treatment of territories

(1) In general

The Secretary may waive any provision of this section (including subsection (h)(2)(D)) in the case of a resident of a State (other than the 50 States and the District of Columbia) insofar as the Secretary determines it is necessary to secure access to negotiated prices for discount card eligible individuals (or, at the option of the Secretary, individuals described in subsection (b)(1)(A)(i)).

(2) Transitional assistance

(A) In general

In the case of a State, other than the 50 States and the District of Columbia, if the State establishes a plan described in subparagraph (B) (for providing transitional assistance with respect to the provision of prescription drugs to some or all individuals residing in the State who are described in subparagraph (B)(i)), the Secretary shall pay to the State for the entire period of the operation of this section an amount equal to the amount allotted to the State under subparagraph (C).

(B) Plan

The plan described in this subparagraph is a plan that—

(i) provides transitional assistance with respect to the provision of covered discount card drugs to some or all individuals who are entitled to benefits under part A or enrolled under part B, who reside in the State, and who have income below 135 percent of the poverty line; and

(ii) assures that amounts received by the State under this paragraph are used only for such assistance.

(C) Allotment limit

The amount described in this subparagraph for a State is equal to $35,000,000 multiplied by the ratio (as estimated by the Secretary) of—

(i) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary as of July 1, 2003), to

(ii) the sum of such numbers for all States to which this paragraph applies.

(D) Continued availability of funds

Amounts made available to a State under this paragraph which are not used under this paragraph shall be added to the amount available to that State for purposes of carrying out section 1396u–5(e) of this title.

(k) Funding

(1) Establishment of Transitional Assistance Account

(A) In general

There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title an account to be known as the ''Transitional Assistance Account'' (in this subsection referred to as the ''Account'').

(B) Funds

The Account shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, the Account as provided in this subsection.

(C) Separate from rest of Trust Fund

Funds provided under this subsection to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(2) Payments from account

(A) In general

The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments for transitional assistance provided under subsections (g) and (j)(2).

(B) Treatment in relation to part B premium

Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1395r of this title.

(3) Appropriations to cover benefits

There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments made from the Account in the year.

(4) For administrative expenses

There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the Secretary's responsibilities under this section.

(5) Transfer of any remaining balance to Medicare Prescription Drug Account

Any balance remaining in the Account after the Secretary determines that funds in the Account are no longer necessary to carry out the program under this section shall be transferred and deposited into the Medicare Prescription Drug Account under section 1395w–116 of this title.

(6) Construction

Nothing in this section shall be construed as authorizing the Secretary to provide for payment (other than payment of an enrollment fee on behalf of a transitional assistance eligible individual under subsection (g)(1)(A)) to a sponsor for administrative expenses incurred by the sponsor in carrying out this section (including in administering the transitional assistance provisions of subsections (f) and (g)).

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–31, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2131.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (f)(3)(B)(iii), is classified generally to Title 26, Internal Revenue Code.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(6)(A), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

Statutory Notes and Related Subsidiaries

RULES FOR IMPLEMENTATION

Pub. L. 108–173, title I, §105(c), Dec. 8, 2003, 117 Stat. 2166, provided that: ''The following rules shall apply to

the medicare prescription drug discount card and transitional assistance program under section 1860D–31 of the Social Security Act [42 U.S.C. 1395w–141], as added by section 101(a):

''(1) In promulgating regulations pursuant to subsection (a)(2)(B) of such section 1860D–31 [42 U.S.C. 1395w–141(a)(2)(B)]—

''(A) section 1871(a)(3) of the Social Security Act (42 U.S.C. 1395hh(a)(3)), as added by section 902(a)(1), shall not apply;

''(B) chapter 35 of title 44, United States Code, shall not apply; and

''(C) sections 553(d) and 801(a)(3)(A) of title 5, United States Code, shall not apply.

''(2) Section 1857(c)(5) of the Social Security Act (42 U.S.C. 1395w–27(c)(5)) shall apply with respect to section 1860D–31 of such Act, as added by section 101(a), in the same manner as it applies to part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.].

''(3) The administration of such program shall be made without regard to chapter 35 of title 44, United States Code.

''(4)(A) There shall be no judicial review of a determination not to endorse, or enter into a contract, with a prescription drug card sponsor under section 1860D–31 of the Social Security Act.

''(B) In the case of any order issued to enjoin any provision of section 1860D–31 of the Social Security Act (or of [sic] any provision of this section [amending sections 1395r, 1395t, and 1396r–8 of this title and sections 6103 and 7213 of Title 26, Internal Revenue Code]), such order shall not affect any other provision of such section (or of this section) and all such provisions shall be treated as severable.''

SUBPART 5—DEFINITIONS AND MISCELLANEOUS PROVISIONS

§ 1395w–151. Definitions; treatment of references to provisions in part C

(a) Definitions

For purposes of this part:

(1) Basic prescription drug coverage

The term ''basic prescription drug coverage'' is defined in section 1395w–102(a)(3) of this title.

(2) Covered part D drug

The term ''covered part D drug'' is defined in section 1395w–102(e) of this title.

(3) Creditable prescription drug coverage

The term ''creditable prescription drug coverage'' has the meaning given such term in section 1395w–113(b)(4) of this title.

(4) Part D eligible individual

The term ''part D eligible individual'' has the meaning given such term in section 1395w–101(a)(3)(A) of this title.[1]

(5) Fallback prescription drug plan

The term ''fallback prescription drug plan'' has the meaning given such term in section 1395w–111(g)(4) of this title.

(6) Initial coverage limit

The term ''initial coverage limit'' means such limit as established under section 1395w–102(b)(3) of this title, or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

(7) Insurance risk

The term ''insurance risk'' means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

(8) MA plan

The term ''MA plan'' has the meaning given such term in section 1395w–101(a)(3)(B) of this title.[1]

(9) MA–PD plan

The term ''MA–PD plan'' has the meaning given such term in section 1395w–101(a)(3)(C) of this title.[1]

(10) Medicare Prescription Drug Account

The term ''Medicare Prescription Drug Account'' means the Account created under section 1395w–116(a) of this title.

(11) PDP approved bid

The term ''PDP approved bid'' has the meaning given such term in section 1395w–113(a)(6) of this title.

(12) PDP region

The term ''PDP region'' means such a region as provided under section 1395w–111(a)(2) of this title.

(13) PDP sponsor

The term ''PDP sponsor'' means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

(14) Prescription drug plan

The term ''prescription drug plan'' means prescription drug coverage that is offered—

(A) under a policy, contract, or plan that has been approved under section 1395w–111(e) of this title; and

(B) by a PDP sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1395w–112(b) of this title.

(15) Qualified prescription drug coverage

The term ''qualified prescription drug coverage'' is defined in section 1395w–102(a)(1) of this title.

(16) Standard prescription drug coverage

The term ''standard prescription drug coverage'' is defined in section 1395w–102(b) of this title.

(17) State Pharmaceutical Assistance Program

The term ''State Pharmaceutical Assistance Program'' has the meaning given such term in section 1395w–133(b) of this title.

(18) Subsidy eligible individual

The term ''subsidy eligible individual'' has the meaning given such term in section 1395w–114(a)(3)(A) of this title.

(b) Application of part C provisions under this part

For purposes of applying provisions of part C under this part with respect to a prescription

[1] See References in Text note below.

drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

(1) any reference to an MA plan included a reference to a prescription drug plan;

(2) any reference to an MA organization or a provider-sponsored organization included a reference to a PDP sponsor;

(3) any reference to a contract under section 1395w–27 of this title included a reference to a contract under section 1395w–112(b) of this title;

(4) any reference to part C included a reference to this part; and

(5) any reference to an election period under section 1395w–21 of this title were a reference to an enrollment period under section 1395w–101 of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–41, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2148.)

Editorial Notes

REFERENCES IN TEXT

Section 1395w–101(a)(3) of this title, referred to in subsec. (a)(4), (8), (9), was in the original ''section 1860D–1(a)(4)'', and was translated as meaning section 1860D–1(a)(3) of act Aug. 14, 1935, which is classified to section 1395w–101(a)(3) of this title, to reflect the probable intent of Congress, because section 1395w–101(a) of this title does not contain a par. (4) and par. (3) defines terms for purposes of this part.

§ 1395w–152. Miscellaneous provisions

(a) Access to coverage in territories

The Secretary may waive such requirements of this part, including section 1395w–103(a)(1) of this title, insofar as the Secretary determines it is necessary to secure access to qualified prescription drug coverage for part D eligible individuals residing in a State (other than the 50 States and the District of Columbia).

(b) Application of demonstration authority

The provisions of section 402 of the Social Security Amendments of 1967 (Public Law 90–248) shall apply with respect to this part and part C in the same manner it applies with respect to parts A and B, except that any reference with respect to a Trust Fund in relation to an experiment or demonstration project relating to prescription drug coverage under this part shall be deemed a reference to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.

(c) Coverage gap rebate for 2010

(1) In general

In the case of an individual described in subparagraphs (A) through (D) of section 1395w–114a(g)(1) of this title who as of the last day of a calendar quarter in 2010 has incurred costs for covered part D drugs so that the individual has exceeded the initial coverage limit under section 1395w–102(b)(3) of this title for 2010, the Secretary shall provide for payment from the Medicare Prescription Drug Account of $250 to the individual by not later than the 15th day of the third month following the end of such quarter.

(2) Limitation

The Secretary shall provide only 1 payment under this subsection with respect to any individual.

(d) Treatment of certain complaints for purposes of quality or performance assessment

In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–42, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2149; amended Pub. L. 111–152, title I, §1101(a)(1), Mar. 30, 2010, 124 Stat. 1036; Pub. L. 114–198, title VII, §704(d), July 22, 2016, 130 Stat. 750.)

Editorial Notes

REFERENCES IN TEXT

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b), is section 402 of Pub. L. 90–248, title IV, Jan. 2, 1968, 81 Stat. 930, which enacted section 1395b–1 of this title and amended section 1395*ll* of this title.

AMENDMENTS

2016—Subsec. (d). Pub. L. 114–198 added subsec. (d).
2010—Subsec. (c). Pub. L. 111–152 added subsec. (c).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

§ 1395w–153. Condition for coverage of drugs under this part

(a) In general

In order for coverage to be available under this part for covered part D drugs (as defined in section 1395w–102(e) of this title) of a manufacturer, the manufacturer must—

(1) participate in the Medicare coverage gap discount program under section 1395w–114a of this title;

(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

(b) Effective date

Subsection (a) shall apply to covered part D drugs dispensed under this part on or after January 1, 2011.

(c) Authorizing coverage for drugs not covered under agreements

Subsection (a) shall not apply to the dispensing of a covered part D drug if—

(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

(2) the Secretary determines that in the period beginning on January 1, 2011, and[1] December 31, 2011, there were extenuating circumstances.

(d) Definition of manufacturer

In this section, the term ''manufacturer'' has the meaning given such term in section 1395w–114a(g)(5) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–43, as added Pub. L. 111–148, title III, § 3301(a), Mar. 23, 2010, 124 Stat. 461; amended Pub. L. 111–152, title I, § 1101(b)(1), Mar. 30, 2010, 124 Stat. 1037.)

Editorial Notes

AMENDMENTS

2010—Subsec. (b). Pub. L. 111–152, § 1101(b)(1)(A), substituted ''January 1, 2011'' for ''July 1, 2010''.

Subsec. (c)(2). Pub. L. 111–152, § 1101(b)(1)(B), substituted ''January 1, 2011, and December 31, 2011,'' for ''July 1, 2010, and ending on December 31, 2010,''.

§ 1395w–154. Improved Medicare prescription drug plan and MA–PD plan complaint system

(a) In general

The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1395kk–1 of this title) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) Model electronic complaint form

The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) Annual reports by the Secretary

The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) Definitions

In this section:

(1) MA–PD plan

The term ''MA–PD plan'' has the meaning given such term in section 1395w–151(a)(9) of this title.

(2) Prescription drug plan

The term ''prescription drug plan'' has the meaning given such term in section 1395w–151(a)(14) of this title.

(3) Secretary

The term ''Secretary'' means the Secretary of Health and Human Services.

(4) System

The term ''system'' means the plan complaint system developed and maintained under subsection (a).

(Pub. L. 111–148, title III, § 3311, Mar. 23, 2010, 124 Stat. 475.)

Editorial Notes

CODIFICATION

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

PART E—MISCELLANEOUS PROVISIONS

Editorial Notes

CODIFICATION

Pub. L. 108–173, title I, § 101(a)(1), Dec. 8, 2003, 117 Stat. 2071, redesignated part D of this subchapter as part E.

Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 275, redesignated part C of this subchapter as part D.

§ 1395x. Definitions

For purposes of this subchapter—

(a) Spell of illness

The term ''spell of illness'' with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1).

(b) Inpatient hospital services

The term ''inpatient hospital services'' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to

[1] So in original. Probably should be followed by ''ending on''.

inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this subchapter for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

(c) Inpatient psychiatric hospital services

The term ''inpatient psychiatric hospital services'' means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

(d) Supplier

The term ''supplier'' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this subchapter.

(e) Hospital

The term ''hospital'' (except for purposes of sections 1395f(d), 1395f(f), and 1395n(b) of this title, subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made under this subchapter must be under the care of a physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1395f(d) and 1395n(b) of this title (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1395f(f)(2) of this title, and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in subsection (j)(1)(A) and (iii) is primarily engaged in pro-

viding, by or under the supervision of individuals referred to in paragraph (1) of subsection (r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1395f(f)(1) of this title, such term includes an institution which (i) is a hospital for purposes of sections 1395f(d), 1395f(f)(2), and 1395n(b) of this title and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1395bb(a) of this title, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body..[1] Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term ''hospital'' also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1395bb of this title. The term ''hospital'' also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term ''hospital'' does not include, unless the context otherwise requires, a critical access hospital (as defined in subsection (mm)(1)) or a rural emergency hospital (as defined in subsection (kkk)(2)).

(f) Psychiatric hospital

The term ''psychiatric hospital'' means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a ''psychiatric hospital''.

[1] So in original.

(g) Outpatient occupational therapy services

The term ''outpatient occupational therapy services'' has the meaning given the term ''outpatient physical therapy services'' in subsection (p), except that ''occupational'' shall be substituted for ''physical'' each place it appears therein.

(h) Extended care services

The term ''extended care services'' means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3), (6), and (7)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (*l*)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(i) Post-hospital extended care services

The term ''post-hospital extended care services'' means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

(j) Skilled nursing facility

The term ''skilled nursing facility'' has the meaning given such term in section 1395i–3(a) of this title.

(k) Utilization review

A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this subchapter and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to subchapter XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it

appropriate, require for purposes of this subchapter that the procedures established pursuant to subchapter XIX be utilized instead of the procedures required by this section.

(*l*) Agreements for transfer between skilled nursing facilities and hospitals

A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1395aa of this title is in effect (or, in the case of a State in which no such agency has an agreement under section 1395aa of this title, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this subchapter.

(m) Home health services

The term ''home health services'' means the following items and services furnished to an individual, who is under the care of a physician, a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), or a physician assistant (as defined in subsection (aa)(5)), by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs and biologicals) and durable medical equipment and applicable disposable devices (as defined in section 1395m(s)(2) of this title) while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital and home infusion therapy (as defined in subsection (iii)(i)). For purposes of paragraphs (1) and (4), the term ''part-time or intermittent services'' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, ''intermittent'' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

(n) Durable medical equipment

The term ''durable medical equipment'' includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical

condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1395i–3(a)(1) of this title), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations) and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

(*o*) Home health agency

The term ''home health agency'' means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians, nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in subsection (gg)), or physician assistants (as defined in subsection (aa)(5)) and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant, or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1395bbb(a) of this title and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

(7) provides the Secretary with a surety bond—

(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

(B) that the Secretary determines is commensurate with the volume of payments to the home health agency; and

(8) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.

(p) Outpatient physical therapy services

The term ''outpatient physical therapy services'' means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of subsection (r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursu-

ant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term ''outpatient physical therapy services'' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this subchapter, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

(q) Physicians' services

The term ''physicians' services'' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

(r) Physician

The term ''physician'', when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7) of this title), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) and with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of subsections (s)(1) and (s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1395y(a)(4) of this title and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1395y(a)(4) of this title) are furnished.

(s) Medical and other health services

The term ''medical and other health services'' means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1395w–3b of this title);

(B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, and, for items and services furnished on or after January 1, 2011, renal dialysis services

(as defined in section 1395rr(b)(14)(B) of this title), including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1395rr(b)(14) of this title to an individual with acute kidney injury (as defined in section 1395m(r)(2) of this title);

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in subsection (r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1395mm of this title to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1395mm(g) of this title to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this subchapter;

(K)(i) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,[2]

(ii) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(L) certified nurse-midwife services;

(M) qualified psychologist services;

(N) clinical social worker services (as defined in subsection (hh)(2));

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;

(P) prostate cancer screening tests (as defined in subsection (*oo*));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp)); and[3]

(S) diabetes outpatient self-management training services (as defined in subsection (qq));

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary;

[2] So in original. Probably should be followed by ''and''.

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

(ii) is not receiving maintenance dialysis for which payment is made under section 1395rr of this title; and

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;

(W) an initial preventive physical examination (as defined in subsection (ww));

(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));

(Y) diabetes screening tests (as defined in subsection (yy));

(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));

(AA) ultrasound screening for abdominal aortic aneurysm (as defined in subsection (bbb)) for an individual—

(i) who receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (as defined in subsection (ww)(1));

(ii) who has not been previously furnished such an ultrasound screening under this subchapter; and

(iii) who—

(I) has a family history of abdominal aortic aneurysm; or

(II) manifests risk factors included in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms;

(BB) additional preventive services (described in subsection (ddd)(1));

(CC) items and services furnished under a cardiac rehabilitation program (as defined in subsection (eee)(1)) or under a pulmonary rehabilitation program (as defined in subsection (fff)(1));

(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined in subsection (eee)(4));

(EE) kidney disease education services (as defined in subsection (ggg));

(FF) personalized prevention plan services (as defined in subsection (hhh));

(GG) home infusion therapy (as defined in subsection (iii)(1)); and

(HH) opioid use disorder treatment services (as defined in subsection (jjj)).

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act [42 U.S.C. 263b]), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but, subject to section 1395m(*l*)(14) of this title, only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration, and COVID–19 vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj));

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr)).

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title) shall be included within paragraph (3) unless such laboratory—

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 353 of the Public Health Service Act [42 U.S.C. 263a]; and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1395f(d) of this title shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

(t) Drugs and biologicals

(1) The term ''drugs'' and the term ''biologicals'', except for purposes of subsection (m)(5) of this section and paragraph (2), include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2)(A) For purposes of paragraph (1), the term ''drugs'' also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), the term ''medically accepted indication'', with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information (or its successor publications), and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

The Secretary may revise the list of compendia in clause (ii)(I) as is appropriate for identifying medically accepted indications for drugs. On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has[4] a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

(u) Provider of services

The term ''provider of services'' means a hospital, critical access hospital, rural emergency hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395n(e) of this title, a fund.

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such

[4] So in original. Probably should be ''have''.

regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) In the case of extended care services, the regulations under subparagraph (A) shall not include provision for specific recognition of a return on equity capital.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if—

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) of this title, and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under subchapter XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this subchapter not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1395i–3 of this title (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1320a(a) of this title in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality improvement organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this subchapter at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this subchapter,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under subchapter XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under subchapter XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this subchapter in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this subchapter for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this chapter (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the surety bond requirement described in subsection (*o*)(7) and the financial security requirement described in subsection (*o*)(8);

(ii) in the case of home health agencies to which the surety bond requirement described in subsection (*o*)(7) and the financial security requirement described in subsection (*o*)(8) apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this subchapter to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this subchapter and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after December 5, 1980, and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation [5] criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.

(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this subchapter.

(ii) For purposes of clause (i), the term ''bona fide emergency services'' means services pro-

[5] So in original. Probably should be ''regulations''.

vided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;

(II) serious impairment to bodily functions; or

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

(L)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean,

(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies, or

(V) October 1, 1998, 106 percent of such median.

(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1395ww(d)(3)(E) of this title and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1395ww(d)(8)(B) of this title, a decision of the Medicare Geographic Classification Review Board under section 1395ww(d)(10) of this title, or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, subject to clause (viii)(I), the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

(II) the agency's unduplicated census count of patients (entitled to benefits under this subchapter) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994 subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.

(viii)(I) In the case of a provider with a 12-month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to ''98 percent'' were a reference to ''100 percent''), the limit otherwise imposed under clause (v) for such provider and period shall be increased by ⅓ of such difference.

(II) Subject to subclause (IV), for new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in

clause (vi)(I) shall be equal to the median described in such clause (determined as if any reference in clause (v) to ''98 percent'' were a reference to ''100 percent'').

(III) Subject to subclause (IV), in the case of a new provider for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

(IV) In the case of a new provider or a provider without a 12-month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this subchapter before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (iii) to reflect variations in wages among different areas.

(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to ''98 percent'' were a reference to ''100 percent''), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.

(x) Notwithstanding any other provision of this subparagraph, in updating any limit under this subparagraph by a home health market basket index for cost reporting periods beginning during each of fiscal years 2000, 2002, and 2003, the update otherwise provided shall be reduced by 1.1 percentage points. With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act [42 U.S.C. 291 et seq., 300q et seq.] that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a provider of services which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iii), that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this subchapter, less depreciation allowed, to the owner of record as of August 5, 1997 (or, in the case of an asset not in existence as of August 5, 1997, the first owner of record of the asset after August 5, 1997).

(ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this subchapter.

(iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1395ff(b) of this title shall not be allowable as reasonable costs.

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this subchapter with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1395*l*(t) of this title is implemented.

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1395*l*(a)(2)(B)(i)(I) of this title by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1395*l*(t) of this title is implemented.

(III) Subclauses (I) and (II) shall not apply to payments with respect to the costs of hospital outpatient services provided by any hospital that is a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) or a critical access hospital (as defined in subsection (mm)(1)).

(IV) In applying subclauses (I) and (II) to services for which payment is made on the basis of a blend amount under section 1395*l*(i)(3)(A)(ii) or 1395*l*(n)(1)(A)(ii) of this title, the costs reflected in the amounts described in sections 1395*l*(i)(3)(B)(i)(I) and 1395*l*(n)(1)(B)(i)(I) of this title, respectively, shall be reduced in accordance with such subclause.[6]

(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1395*l*(t)(8)(B) of this title shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this subchapter shall be reduced—

(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable,

(iii) for cost reporting periods beginning during fiscal year 2000, by 45 percent of such amount otherwise allowable,

(iv) for cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent of such amount otherwise allowable, and

(v) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(V) In determining such reasonable costs for skilled nursing facilities and (beginning with respect to cost reporting periods beginning during fiscal year 2013) for covered skilled nursing services described in section 1395yy(e)(2)(A) of this title furnished by hospital providers of extended care services (as described in section 1395tt of this title), the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurance amounts under this subchapter for individuals who are entitled to benefits under part A and—

(i) are not described in section 1396u–5(c)(6)(A)(ii) of this title shall be reduced by—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, 30 percent of such amount otherwise allowable; and

(II) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by[7] 35 percent of such amount otherwise allowable.

(ii) are described in such section—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, shall not be reduced;

(II) for cost reporting periods beginning during fiscal year 2013, shall be reduced by 12 percent of such amount otherwise allowable;

(III) for cost reporting periods beginning during fiscal year 2014, shall be reduced by 24 percent of such amount otherwise allowable; and

(IV) for cost reporting periods beginning during a subsequent fiscal year, shall be reduced by 35 percent of such amount otherwise allowable.

(W)(i) In determining such reasonable costs for providers described in clause (ii), the amount of bad debts otherwise treated as allowable costs which are attributable to deductibles and coinsurance amounts under this subchapter shall be reduced—

(I) for cost reporting periods beginning during fiscal year 2013, by 12 percent of such amount otherwise allowable;

(II) for cost reporting periods beginning during fiscal year 2014, by 24 percent of such amount otherwise allowable; and

(III) for cost reporting periods beginning during a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(ii) A provider described in this clause is a provider of services not described in subparagraph (T) or (V), a supplier, or any other type of entity that receives payment for bad debts under the authority under subparagraph (A).

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this subchapter with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this subchapter furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psy-

[6] So in original. Probably should be ''subclauses.''

[7] So in original. The word ''by'' probably should not appear.

chiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this subchapter, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this subchapter for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1395cc(a)(2)(B)(ii)[8] of this title, the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) (including through the operation of subsection (g)) the amount included in any payment to such provider or other organization under this subchapter as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of subsection (p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term, ''semi-private accommodations'' means two-bed, three-bed, or four-bed accommodations.

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

(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1395ww of this title.

(C) For provisions restricting payment for provider-based physicians' services and for payments under certain percentage arrangements, see section 1395xx of this title.

(D) For further limitations on reasonable cost and determination of payment amounts for routine service costs of skilled nursing facilities, see subsections (a) through (c) of section 1395yy of this title.

(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

(i) entertainment, including tickets to sporting and other entertainment events;

(ii) gifts or donations;

(iii) personal use of motor vehicles;

(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

(v) education expenses for spouses or other dependents of providers of services, their employees or contractors.

(w) Arrangements for certain services; payments pursuant to arrangements for utilization review activities

(1) The term ''arrangements'' is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this subchapter, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of subchapter XI of this chapter with respect to services furnished by a hospital or critical access hospital to patients insured under part A of this subchapter or entitled to have payment made for such services under part B of this subchapter or under a State plan approved under subchapter XIX, by a quality improvement organization designated for the area in which such hospital or critical access hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital or critical access hospital and such organization under which such hospital or critical access hospital is obligated to pay to such organization, as a condition of receiving payment for hospital or critical ac-

[8] See References in Text note below.

cess hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or critical access hospital to such patients.

(x) State and United States

The terms ''State'' and ''United States'' have the meaning given to them by subsections (h) and (i), respectively, of section 410 of this title.

(y) Extended care in religious nonmedical health care institutions

(1) The term ''skilled nursing facility'' also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title.

(2) Notwithstanding any other provision of this subchapter, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1395e(a)(3) of this title).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

(z) Institutional planning

An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1320a–1(g)(1) of this title in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1320a–1(b) of this title, or if no such agency is designated, to the appropriate health planning agency in the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1320a–1 of this title by reason of section 1320a–1(j) of this title);

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

(aa) Rural health clinic services and Federally qualified health center services

(1) The term ''rural health clinic services'' means—

(A) physicians' services and such services and supplies as are covered under subsection (s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in subsection (s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or

intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term ''rural health clinic'' means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1395cc of this title, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this subchapter;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this subchapter, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 4-year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act [42 U.S.C. 254b(b)(3), 300e–1(7)], (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act [42 U.S.C. 254e(a)(1)(A)] because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5)[8] of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act [42 U.S.C. 254e(a)(1)(B)], (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this subchapter, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1395*l* of this title, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this subchapter or subchapter XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this subchapter and subchapter XIX, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall

notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term ''Federally qualified health center services'' means—

(A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in subsection (ddd)(3)); and

(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act [42 U.S.C. 254b],

when furnished to an individual as an outpatient of a Federally qualified health center by the center or by a health care professional under contract with the center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term ''Federally qualified health center'' means an entity which—

(A)(i) is receiving a grant under section 330 of the Public Health Service Act [42 U.S.C. 254b], or

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act [42 U.S.C. 254b];

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act [25 U.S.C. 5321 et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(5)(A) The term ''physician assistant'' and the term ''nurse practitioner'' mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term ''clinical nurse specialist'' means, for purposes of this subchapter, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term ''collaboration'' means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

(bb) Services of a certified registered nurse anesthetist

(1) The term ''services of a certified registered nurse anesthetist'' means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term ''certified registered nurse anesthetist'' means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

(cc) Comprehensive outpatient rehabilitation facility services

(1) The term ''comprehensive outpatient rehabilitation facility services'' means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this subchapter.

(2) The term ''comprehensive outpatient rehabilitation facility'' means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in subsection (r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z);

(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.

(dd) Hospice care; hospice program; definitions; certification; waiver by Secretary

(1) The term ''hospice care'' means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,

(C) medical social services under the direction of a physician,

(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians' services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this subchapter.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term ''hospice program'' means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals and services described in section 1395d(a)(5) of this title,

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subpara-

graphs (A), (C), and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1395d(d) of this title with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker,

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor,

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be ''terminally ill'' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

(B) The term ''attending physician'' means, with respect to an individual, the physician (as defined in subsection (r)(1)), the nurse practitioner (as defined in subsection (aa)(5)), or the physician assistant (as defined in such subsection), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this subchapter so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1395cc of this title and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this subchapter.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(ii)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) or (C), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) or (C) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages

due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.

(ee) Discharge planning process

(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this subchapter and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1395a of this title, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1395cc(a)(1)(S) of this title) or which has such an interest in the hospital.

(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

(B) notwithstanding subparagraph (H)(i)[9], the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.

(ff) Partial hospitalization services

(1) The term ''partial hospitalization services'' means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The items and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual's condition),

[9] So in original. Probably should be ''paragraph (2)(H)(i)''.

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential setting.

(B) For purposes of subparagraph (A), the term ''community mental health center'' means an entity that—

(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act [42 U.S.C. 300x–2(c)(1)]; or

(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located;

(iii) provides at least 40 percent of its services to individuals who are not eligible for benefits under this subchapter; and

(iv) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act [42 U.S.C. 300x–31(c)(1)].

(gg) Certified nurse-midwife services

(1) The term ''certified nurse-midwife services'' means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife's service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physicians' service.

(2) The term ''certified nurse-midwife'' means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

(hh) Clinical social worker; clinical social worker services

(1) The term ''clinical social worker'' means an individual who—

(A) possesses a master's or doctor's degree in social work;

(B) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)(i) is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii) in the case of an individual in a State which does not provide for licensure or certification—

(I) has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

(II) meets such other criteria as the Secretary establishes.

(2) The term ''clinical social worker services'' means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

(ii) Qualified psychologist services

The term ''qualified psychologist services'' means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

(jj) Screening mammography

The term ''screening mammography'' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.

(kk) Covered osteoporosis drug

The term ''covered osteoporosis drug'' means an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—

(1) the individual's attending physician, nurse practitioner or clinical nurse specialist (as those terms are defined in subsection

(aa)(5)), certified nurse-midwife (as defined in subsection (gg)), or physician assistant (as defined in subsection (aa)(5)) certifies that the individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7)).

(*ll*) Speech-language pathology services; audiology services

(1) The term ''speech-language pathology services'' means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

(2) The term ''outpatient speech-language pathology services'' has the meaning given the term ''outpatient physical therapy services'' in subsection (p), except that in applying such subsection—

(A) ''speech-language pathology'' shall be substituted for ''physical therapy'' each place it appears; and

(B) ''speech-language pathologist'' shall be substituted for ''physical therapist'' each place it appears.

(3) The term ''audiology services'' means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

(4) In this subsection:

(A) The term ''qualified speech-language pathologist'' means an individual with a master's or doctoral degree in speech-language pathology who—

(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

(B) The term ''qualified audiologist'' means an individual with a master's or doctoral degree in audiology who—

(i) is licensed as an audiologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

(mm) Critical access hospital; critical access hospital services

(1) The term ''critical access hospital'' means a facility certified by the Secretary as a critical access hospital under section 1395i–4(e) of this title.

(2) The term ''inpatient critical access hospital services'' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

(3) The term ''outpatient critical access hospital services'' means medical and other health services furnished by a critical access hospital on an outpatient basis.

(nn) Screening pap smear; screening pelvic exam

(1) The term ''screening pap smear'' means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3).

(2) The term ''screening pelvic exam'' means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

(3) A woman described in this paragraph is a woman who—

(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).

(*oo*) Prostate cancer screening tests

(1) The term ''prostate cancer screening test'' means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2002, such other procedures as the Secretary finds appro-

priate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

(pp) Colorectal cancer screening tests

(1) The term ''colorectal cancer screening test'' means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal-occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) Screening colonoscopy.

(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) An ''individual at high risk for colorectal cancer'' is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

(qq) Diabetes outpatient self-management training services

(1) The term ''diabetes outpatient self-management training services'' means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

(2) In paragraph (1)—

(A) a ''certified provider'' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this subchapter; and

(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this subchapter) with diabetes as meeting standards for furnishing the services.

(rr) Bone mass measurement

(1) The term ''bone mass measurement'' means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

(2) For purposes of this subsection, the term ''qualified individual'' means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen-deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long-term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this subchapter.

(ss) Religious nonmedical health care institution

(1) The term ''religious nonmedical health care institution'' means an institution that—

(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

(G)(i) is not owned by, under common ownership with, or has an ownership interest in, a provider of medical treatment or services;

(ii) is not affiliated with—

(I) a provider of medical treatment or services, or

(II) an individual who has an ownership interest in a provider of medical treatment or services;

(H) has in effect a utilization review plan which—

(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

(I) provides the Secretary with such information as the Secretary may require to implement section 1395i–5 of this title, including information relating to quality of care and coverage determinations; and

(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

(3)(A)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1395i–5(a)(2) of this title the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

(B)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.

(tt) Post-institutional home health services; home health spell of illness

(1) The term ''post-institutional home health services'' means home health services furnished to an individual—

(A) after discharge from a hospital or critical access hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term ''home health spell of illness'' with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1) nor provided home health services.

(uu) Screening for glaucoma

The term ''screening for glaucoma'' means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, if the individual involved has not had such an examination in the preceding year.

(vv) Medical nutrition therapy services; registered dietitian or nutrition professional

(1) The term ''medical nutrition therapy services'' means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

(2) Subject to paragraph (3), the term ''registered dietitian or nutrition professional'' means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of December 21, 2000, is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.

(ww) Initial preventive physical examination

(1) The term ''initial preventive physical examination'' means physicians' services consisting of a physical examination (including measurement of height, weight body mass index,,[10] and blood pressure) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual, and the furnishing of a review of any current opioid prescriptions (as defined in paragraph (4)), but does not include clinical laboratory tests.

(2) The screening and other preventive services described in this paragraph include the following:

(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

(B) Screening mammography as defined in subsection (jj).

(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

(D) Prostate cancer screening tests as defined in subsection (*oo*).

(E) Colorectal cancer screening tests as defined in subsection (pp).

(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

(G) Bone mass measurement as defined in subsection (rr).

(H) Screening for glaucoma as defined in subsection (uu).

(I) Medical nutrition therapy services as defined in subsection (vv).

(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

(K) Diabetes screening tests as defined in subsection (yy).

(L) Ultrasound screening for abdominal aortic aneurysm as defined in subsection (bbb).

(M) An electrocardiogram.

(N) Screening for potential substance use disorders.

(O) Additional preventive services (as defined in subsection (ddd)(1)).

(3) For purposes of paragraph (1), the term ''end-of-life planning'' means verbal or written information regarding—

(A) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and

(B) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

(4) For purposes of paragraph (1), the term ''a review of any current opioid prescriptions'' means, with respect to an individual determined to have a current prescription for opioids—

(A) a review of the potential risk factors to the individual for opioid use disorder;

(B) an evaluation of the individual's severity of pain and current treatment plan;

(C) the provision of information on non-opioid treatment options; and

(D) a referral to a specialist, as appropriate.

(xx) Cardiovascular screening blood test

(1) The term ''cardiovascular screening blood test'' means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

(A) Cholesterol levels and other lipid or triglyceride levels.

(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.

(yy) Diabetes screening tests

(1) The term ''diabetes screening tests'' means testing furnished to an individual at risk for di-

[10] So in original. Probably should be ''weight, body mass index,''.

abetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

(A) a fasting plasma glucose test; and

(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) For purposes of paragraph (1), the term ''individual at risk for diabetes'' means an individual who has any of the following risk factors for diabetes:

(A) Hypertension.

(B) Dyslipidemia.

(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

(D) Previous identification of an elevated impaired fasting glucose.

(E) Previous identification of impaired glucose tolerance.

(F) A risk factor consisting of at least 2 of the following characteristics:

(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

(ii) A family history of diabetes.

(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(iv) 65 years of age or older.

(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

(zz) Intravenous immune globulin

The term ''intravenous immune globulin'' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.

(aaa) Extended care in religious nonmedical health care institutions

(1) The term ''home health agency'' also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title.

(B) Notwithstanding any other provision of this subchapter, payment may not be made under subparagraph (A)—

(i) in a year insofar as such payments exceed $700,000; and

(ii) after December 31, 2006.

(bbb) Ultrasound screening for abdominal aortic aneurysm

The term ''ultrasound screening for abdominal aortic aneurysm'' means—

(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, that the Secretary may specify) provided for the early detection of abdominal aortic aneurysm; and

(2) includes a physician's interpretation of the results of the procedure.

(ccc) Long-term care hospital

The term ''long-term care hospital'' means a hospital which—

(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

(2) has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or meets the requirements of clause (II)[8] of section 1395ww(d)(1)(B)(iv) of this title;

(3) satisfies the requirements of subsection (e); and

(4) meets the following facility criteria:

(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary; and

(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient.

(ddd) Additional preventive services; preventive services

(1) The term ''additional preventive services'' means services not described in subparagraph (A) or (C) of paragraph (3) that identify medical conditions or risk factors and that the Secretary determines are—

(A) reasonable and necessary for the prevention or early detection of an illness or disability;

(B) recommended with a grade of A or B by the United States Preventive Services Task Force; and

(C) appropriate for individuals entitled to benefits under part A or enrolled under part B.

(2) In making determinations under paragraph (1) regarding the coverage of a new service, the Secretary shall use the process for making national coverage determinations (as defined in section 1395ff(f)(1)(B) of this title) under this subchapter. As part of the use of such process, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.

(3) The term ''preventive services'' means the following:

(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

(B) An initial preventive physical examination (as defined in subsection (ww)).

(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).

(eee) Cardiac rehabilitation program; intensive cardiac rehabilitation program

(1) The term ''cardiac rehabilitation program'' means a physician-supervised program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3).

(2) A program described in this paragraph is a program under which—

(A) items and services under the program are delivered—

(i) in a physician's office;

(ii) in a hospital on an outpatient basis; or

(iii) in other settings determined appropriate by the Secretary.

(B) a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

(C) individualized treatment is furnished under a written plan established, reviewed, and signed by a physician every 30 days that describes—

(i) the individual's diagnosis;

(ii) the type, amount, frequency, and duration of the items and services furnished under the plan; and

(iii) the goals set for the individual under the plan.

(3) The items and services described in this paragraph are—

(A) physician-prescribed exercise;

(B) cardiac risk factor modification, including education, counseling, and behavioral intervention (to the extent such education, counseling, and behavioral intervention is closely related to the individual's care and treatment and is tailored to the individual's needs);

(C) psychosocial assessment;

(D) outcomes assessment; and

(E) such other items and services as the Secretary may determine, but only if such items and services are—

(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(4)(A) The term ''intensive cardiac rehabilitation program'' means a physician-supervised program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) and has shown, in peer-reviewed published research, that it accomplished—

(i) one or more of the following:

(I) positively affected the progression of coronary heart disease; or

(II) reduced the need for coronary bypass surgery; or

(III) reduced the need for percutaneous coronary interventions; and

(ii) a statistically significant reduction in 5 or more of the following measures from their level before receipt of cardiac rehabilitation services to their level after receipt of such services:

(I) low density lipoprotein;

(II) triglycerides;

(III) body mass index;

(IV) systolic blood pressure;

(V) diastolic blood pressure; or

(VI) the need for cholesterol, blood pressure, and diabetes medications.

(B) To be eligible for an intensive cardiac rehabilitation program, an individual must have—

(i) had an acute myocardial infarction within the preceding 12 months;

(ii) had coronary bypass surgery;

(iii) stable angina pectoris;

(iv) had heart valve repair or replacement;

(v) had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;

(vi) had a heart or heart-lung transplant;

(vii) stable, chronic heart failure (defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks); or

(viii) any additional condition for which the Secretary has determined that a cardiac rehabilitation program shall be covered, unless the Secretary determines, using the same process used to determine that the condition is covered for a cardiac rehabilitation program, that such coverage is not supported by the clinical evidence.

(C) An intensive cardiac rehabilitation program may be provided in a series of 72 one-hour sessions (as defined in section 1395w–4(b)(5) of this title), up to 6 sessions per day, over a period of up to 18 weeks.

(5) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with cardiac

pathophysiology who is licensed to practice medicine in the State in which a cardiac rehabilitation program (or the intensive cardiac rehabilitation program, as the case may be) is offered—

(A) is responsible for such program; and

(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual[1] in the program.

(fff) Pulmonary rehabilitation program

(1) The term ''pulmonary rehabilitation program'' means a physician-supervised program (as described in subsection (eee)(2) with respect to a program under this subsection) that furnishes the items and services described in paragraph (2).

(2) The items and services described in this paragraph are—

(A) physician-prescribed exercise;

(B) education or training (to the extent the education or training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs);

(C) psychosocial assessment;

(D) outcomes assessment; and

(E) such other items and services as the Secretary may determine, but only if such items and services are—

(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(3) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with respiratory pathophysiology who is licensed to practice medicine in the State in which a pulmonary rehabilitation program is offered—

(A) is responsible for such program; and

(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual[1] in the program.

(ggg) Kidney disease education services

(1) The term ''kidney disease education services'' means educational services that are—

(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

(C) designed—

(i) to provide comprehensive information (consistent with the standards set under paragraph (3)) regarding—

(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

(II) the prevention of uremic complications; and

(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

(iii) to be tailored to meet the needs of the individual involved.

(2)(A) The term ''qualified person'' means—

(i) a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in subsection (aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1395w–4 of this title; and

(ii) a provider of services located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(B) Such term does not include a provider of services (other than a provider of services described in subparagraph (A)(ii)) or a renal dialysis facility.

(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1395rr(c)(2) of this title, and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this subchapter.

(hhh) Annual wellness visit

(1) The term ''personalized prevention plan services'' means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

(A) The establishment of, or an update to, the individual's medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appro-

priate), blood pressure, and other routine measurements.

(D) Detection of any cognitive impairment.

(E) The establishment of, or an update to, the following:

(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered under this subchapter.

(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(G) Screening for potential substance use disorders and referral for treatment as appropriate.

(H) The furnishing of a review of any current opioid prescriptions (as defined in subsection (ww)(4)).

(I) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1395u(b)(18)(C) of this title; or

(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after March 23, 2010, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

(II) during an encounter with a health care professional;

(III) through community-based prevention programs; or

(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

(B) Not later than 1 year after March 23, 2010, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 300u–12(f) of this title as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

(C)(i) Not later than 18 months after March 23, 2010, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.

(H) The Secretary shall issue guidance that—

(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.

(iii) Home infusion therapy

(1) The term ''home infusion therapy'' means the items and services described in paragraph (2)

furnished by a qualified home infusion therapy supplier (as defined in paragraph (3)(D)) which are furnished in the individual's home (as defined in paragraph (3)(B)) to an individual—

(A) who is under the care of an applicable provider (as defined in paragraph (3)(A)); and

(B) with respect to whom a plan prescribing the type, amount, and duration of infusion therapy services that are to be furnished such individual has been established by a physician (as defined in subsection (r)(1)) and is periodically reviewed by a physician (as so defined) in coordination with the furnishing of home infusion drugs (as defined in paragraph (3)(C)) under part B.

(2) The items and services described in this paragraph are the following:

(A) Professional services, including nursing services, furnished in accordance with the plan.

(B) Training and education (not otherwise paid for as durable medical equipment (as defined in subsection (n)), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

(3) For purposes of this subsection:

(A) The term ''applicable provider'' means—

(i) a physician;

(ii) a nurse practitioner; and

(iii) a physician assistant.

(B) The term ''home'' means a place of residence used as the home of an individual (as defined for purposes of subsection (n)).

(C) The term ''home infusion drug'' means a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in subsection (n)). Such term does not include the following:

(i) Insulin pump systems.

(ii) A self-administered drug or biological on a self-administered drug exclusion list.

Clause (ii) shall not apply to a self-administered drug or biological on a self-administered drug exclusion list if such drug or biological was included as a transitional home infusion drug under subparagraph (A)(iii) of section 1395m(u)(7) of this title and was identified by a HCPCS code described in subparagraph (C)(ii) of such section.

(D)(i) The term ''qualified home infusion therapy supplier'' means a pharmacy, physician, or other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider or services or supplier furnishes items or services and that—

(I) furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;

(II) ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;

(III) is accredited by an organization designated by the Secretary pursuant to section 1395m(u)(5) of this title; and

(IV) meets such other requirements as the Secretary determines appropriate, taking into account the standards of care for home infusion therapy established by Medicare Advantage plans under part C and in the private sector.

(ii) A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet the requirements of this subparagraph.

(jjj) Opioid use disorder treatment services; opioid treatment program

(1) Opioid use disorder treatment services

The term ''opioid use disorder treatment services'' means items and services that are furnished by an opioid treatment program for the treatment of opioid use disorder, including—

(A) opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 355 of title 21 for use in the treatment of opioid use disorder;

(B) dispensing and administration of such medications, if applicable;

(C) substance use counseling by a professional to the extent authorized under State law to furnish such services;

(D) individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law);

(E) toxicology testing, and

(F) other items and services that the Secretary determines are appropriate (but in no event to include meals or transportation).

(2) Opioid treatment program

The term ''opioid treatment program'' means an entity that is an opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any successor regulation) that—

(A) is enrolled under section 1395cc(j) of this title;

(B) has in effect a certification by the Substance Abuse and Mental Health Services Administration for such a program;

(C) is accredited by an accrediting body approved by the Substance Abuse and Mental Health Services Administration; and

(D) meets such additional conditions as the Secretary may find necessary to ensure—

(i) the health and safety of individuals being furnished services under such program; and

(ii) the effective and efficient furnishing of such services.

(kkk) Rural emergency hospital services; rural emergency hospital

(1) Rural emergency hospital services

(A) In general

The term ''rural emergency hospital services'' means the following services furnished by a rural emergency hospital (as defined in paragraph (2)) that do not exceed an annual per patient average of 24 hours in such rural emergency hospital:

(i) Emergency department services and observation care.

(ii) At the election of the rural emergency hospital, with respect to services furnished on an outpatient basis, other medical and health services as specified by the Secretary through rulemaking.

(B) Staffed emergency department

For purposes of subparagraph (A)(i), an emergency department of a rural emergency hospital shall be considered a staffed emergency department if it meets the following requirements:

(i) The emergency department is staffed 24 hours a day, 7 days a week.

(ii) A physician (as defined in subsection (r)(1)), nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in subsection (aa)(5)) is available to furnish rural emergency hospital services in the facility 24 hours a day.

(iii) Applicable staffing and staffing responsibilities under section 485.631 of title 42, Code of Federal Regulations (or any successor regulation).

(2) Rural emergency hospital

The term ''rural emergency hospital'' means a facility described in paragraph (3) that—

(A) is enrolled under section 1395cc(j) of this title, submits the additional information described in paragraph (4)(A) for purposes of such enrollment, and makes the detailed transition plan described in clause (i) of such paragraph available to the public, in a form and manner determined appropriate by the Secretary;

(B) does not provide any acute care inpatient services, other than those described in paragraph (6)(A);

(C) has in effect a transfer agreement with a level I or level II trauma center;

(D) meets—

(i) licensure requirements as described in paragraph (5);

(ii) the requirements of a staffed emergency department as described in paragraph (1)(B);

(iii) such staff training and certification requirements as the Secretary may require;

(iv) conditions of participation applicable to—

(I) critical access hospitals, with respect to emergency services under section 485.618 of title 42, Code of Federal Regulations (or any successor regulation); and

(II) hospital emergency departments under this subchapter, as determined applicable by the Secretary;

(v) such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished rural emergency hospital services; and

(vi) in the case where the rural emergency hospital includes a distinct part unit of the facility that is licensed as a skilled nursing facility, such distinct part meets the requirements applicable to skilled nursing facilities under this subchapter.

(3) Facility described

A facility described in this paragraph is a facility that as of December 27, 2020—

(A) was a critical access hospital; or

(B) was a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title), or was a subsection (d) hospital (as so defined) with not more than 50 beds that was treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title.

(4) Additional information

(A) Information

For purposes of paragraph (2)(A), a facility that submits an application for enrollment under section 1395cc(j) of this title as a rural emergency hospital shall submit the following information at such time and in such form as the Secretary may require:

(i) An action plan for initiating rural emergency hospital services (as defined in paragraph (1)), including a detailed transition plan that lists the specific services that the facility will—

(I) retain;

(II) modify[11]

(III) add; and

(IV) discontinue.

(ii) A description of services that the facility intends to furnish on an outpatient basis pursuant to paragraph (1)(A)(ii).

(iii) Information regarding how the facility intends to use the additional facility payment provided under section 1395m(x)(2) of this title, including a description of the services covered under this subchapter that the additional facility payment would be supporting, such as furnishing telehealth services and ambulance services, including operating the facility and maintaining the emergency department to provide such services covered under this subchapter.

(iv) Such other information as the Secretary determines appropriate.

(B) Effect of enrollment

Such enrollment shall remain effective with respect to a facility until such time as—

(i) the facility elects to convert back to its prior designation as a critical access hospital or a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), subject to requirements applicable under this subchapter for such designation and in accordance with procedures established by the Secretary; or

(ii) the Secretary determines the facility does not meet the requirements applicable to a rural emergency hospital under this subsection.

[11] So in original. Probably should be followed by a semicolon.

(5) Licensure

A facility may not operate as a rural emergency hospital in a State unless the facility—

(A) is located in a State that provides for the licensing of such hospitals under State or applicable local law; and

(B)(i) is licensed pursuant to such law; or

(ii) is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing.

(6) Discretionary authority

A rural emergency hospital may—

(A) include a unit of the facility that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services; and

(B) be considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1395*l*(f) of this title.

(7) Quality measurement

(A) In general

The Secretary shall establish quality measurement reporting requirements for rural emergency hospitals, which may include the use of a small number of claims-based outcomes measures or surveys of patients with respect to their experience in the rural emergency hospital, in accordance with the succeeding provisions of this paragraph.

(B) Quality reporting by rural emergency hospitals

(i) In general

With respect to each year beginning with 2023, (or each year beginning on or after the date that is one year after one or more measures are first specified under subparagraph (C)), a rural emergency hospital shall submit data to the Secretary in accordance with clause (ii).

(ii) Submission of quality data

With respect to each such year, a rural emergency hospital shall submit to the Secretary data on quality measures specified under subparagraph (C). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(C) Quality measures

(i) In general

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

(ii) Exception

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

(iii) Consideration of low case volume when specifying performance measures

The Secretary shall, in the selection of measures specified under this subparagraph, take into consideration ways to account for rural emergency hospitals that lack sufficient case volume to ensure that the performance rates for such measures are reliable.

(D) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (B) available to the public regarding the performance of individual rural emergency hospitals. Such procedures shall ensure that a rural emergency hospital has the opportunity to review, and submit corrections for, the data that is to be made public with respect to the rural emergency hospital prior to such data being made public. Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format as determined appropriate by the Secretary.

(8) Clarification regarding application of provisions relating to off-campus outpatient department of a provider

Nothing in this subsection, section 1395*l*(a)(10) of this title, or section 1395m(x) of this title shall affect the application of paragraph (1)(B)(v) of section 1395*l*(t) of this title, relating to applicable items and services (as defined in subparagraph (A) of paragraph (21) of such section) that are furnished by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(9) Implementation

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of the following:

(A) The determination of whether a rural emergency hospital meets the requirements of this subsection.

(B) The establishment of requirements under this subsection by the Secretary, including requirements described in paragraphs (2)(D), (4), and (7).

(C) The determination of payment amounts under section 1395m(x) of this title, including the additional facility payment described in paragraph (2) of such section.

(Aug. 14, 1935, ch. 531, title XVIII, §1861, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 313; amended Pub. L. 89–713, §7, Nov. 2, 1966, 80 Stat. 1111; Pub. L. 90–248, title I, §§127(a), 129(a), (b), (c)(9)(C), (10), (11), 132(a), 133(a), (b), 134(a), 143(a), 144(a)–(d), Jan. 2, 1968, 81 Stat. 846–850, 852, 857, 858; Pub. L. 91–690, Jan. 12, 1971, 84 Stat. 2074; Pub. L. 92–603, title II, §§211(b), (c)(2), 221(c)(4), 223(a)–(d), (f), 227(a), (c), (d)(1), (f), 234(a)–(f), 237(c), 244(c), 246(b), 248, 249(b), 251(a)(1), (b)(1), (c), 252(a), 256(b), 264(a), 265, 267, 273(a), 276(a), 278(a) (4)–(15), (b)(6), (10), (11), (13),

283(a), Oct. 30, 1972, 86 Stat. 1383, 1384, 1389, 1393, 1394, 1404–1407, 1412, 1413, 1416, 1423–1426, 1445–1447, 1449–1454, 1456; Pub. L. 94–182, title I, §§102, 106(a), 112(a)(1), Dec. 31, 1975, 89 Stat. 1051, 1052, 1055; Pub. L. 95–142, §§3(a)(2), 5(m), 19(b)(1), 21(a), Oct. 25, 1977, 91 Stat. 1178, 1191, 1204, 1207; Pub. L. 95–210, §1(d), (g), (h), Dec. 13, 1977, 91 Stat. 1485, 1487, 1488; Pub. L. 95–216, title V, §501(a), Dec. 20, 1977, 91 Stat. 1564; Pub. L. 95–292, §4(d), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§902(a)(1), 915(a), 930(k)–(n), (p), 931(c), (d), 933(c)–(e), 936(a), 937(a), 938(a), 948(a)(1), 949, 950, 951(a), (b), 952(a), formerly 952, Dec. 5, 1980, 94 Stat. 2612, 2623, 2632, 2633, 2635, 2639, 2640, 2643, 2645, 2646; Pub. L. 96–611, §1(a)(1), (b)(3), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§2102(a), 2114, 2121(c), (d), 2141(a), 2142(a), 2143(a), 2144(a), 2193(c)(9), Aug. 13, 1981, 95 Stat. 787, 796–799, 828; Pub. L. 97–248, title I, §§101(a)(2), (d), 102(a), 103(a), 105(a), 106(a), 107(a), 108(a)(2), 109(b), 114(b), 122(d), 127(1), 128(a)(1), (d)(2), 148(b), Sept. 3, 1982, 96 Stat. 335–339, 350, 359, 366, 367, 394; Pub. L. 97–448, title III, §309(a)(4), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 98–21, title VI, §§602(d), 607(b)(2), (d), Apr. 20, 1983, 97 Stat. 163, 171, 172; Pub. L. 98–369, div. B, title III, §§2314(a), 2318(a), (b), 2319(a), 2321(e), 2322(a), 2323(a), 2324(a), 2335(b), 2340(a), 2341(a), (c), 2342(a), 2343(a), (b), 2354(b)(18)–(29), July 18, 1984, 98 Stat. 1079, 1081, 1082, 1085, 1086, 1090, 1093, 1094, 1101; Pub. L. 98–617, §3(a)(4), (b)(7), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§9107(b), 9110(a), 9202(i)(1), 9219(b)(1)(B), (3)(A), Apr. 7, 1986, 100 Stat. 160, 162, 177, 182, 183; Pub. L. 99–509, title IX, §§9305(c)(1), (2), 9313(a)(2), 9315(a), 9320(b), (c), (f), 9335(c)(1), 9336(a), 9337(d), 9338(a), Oct. 21, 1986, 100 Stat. 1989, 2002, 2005, 2013, 2015, 2030, 2033, 2034; Pub. L. 100–203, title IV, §§4009(e)(1), (f), 4021(a), 4026(a)(1), 4039(b), 4064(e)(1), 4065(a), 4070(b)(1), (2), 4071(a), 4072(a), 4073(a), (c), 4074(a), (b), 4075(a), 4076(a), 4077(a)(1), (b)(1), (4), formerly (5), 4078, 4084(c)(1), 4085(i)(9)–(14), 4201(a)(1), (b)(1), (d)(1), (2), (5), formerly (d), Dec. 22, 1987, 101 Stat. 1330–57, 1330–58, 1330–67, 1330–74, 1330–81, 1330–111, 1330–112, 1330–114, 1330–116, 1330–118 to 1330–121, 1330–132, 1330–133, 1330–160, 1330–174, as amended Pub. L. 100–360, title IV, §411(h)(4)(D), (5)–(7)(A), (E), (F), (i)(3), (4)(C)(iii), (*l*)(1)(B), (C), July 1, 1988, 102 Stat. 787–789, 801, as amended Pub. L. 100–485, title VI, §608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title I, §104(d)(4), title II, §§202(a), 203(b), (e)(1), 204(a), 205(b), 206(a), title IV, §411(d)(1)(B)(i), (5)(A), (g)(3)(H), (h)(1)(B), (2), (3)(A), July 1, 1988, 102 Stat. 689, 702, 721, 725, 730, 731, 773, 774, 785, 786; Pub. L. 100–485, title VI, §608(d)(6)(A), (23)(B), Oct. 13, 1988, 102 Stat. 2414, 2421; Pub. L. 100–647, title VIII, §§8423(a), 8424(a), Nov. 10, 1988, 102 Stat. 3803; Pub. L. 101–234, title I, §101(a), title II, §201(a), Dec. 13, 1989, 103 Stat. 1979, 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(A), (C)(i), (D)(x), 6110, 6112(e)(1), 6113(a)–(b)(2), 6114(a), (d), 6115(a), 6116(a)(1), 6131(a)(2), 6141(a), 6213(a)–(c), Dec. 19, 1989, 103 Stat. 2151–2153, 2213, 2215–2219, 2221, 2225, 2250, 2251; Pub. L. 101–508, title IV, §§4008(h)(2)(A)(i), 4151(a), (b)(1), 4152(a)(2), 4153(b)(2)(A), 4155(a), (d), 4156(a), 4157(a), 4161(a)(1), (2), (5), (b)(1), (2), 4162(a), 4163(a), 4201(d)(1), 4207(d)(1), formerly 4027(d)(1), Nov. 5, 1990, 104 Stat. 1388–48, 1388–71, 1388–72, 1388–74, 1388–84, 1388–86 to 1388–88, 1388–93 to 1388–96, 1388–104, 1388–120, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 101–597, title IV, §401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–66, title XIII, §§13503(c)(1)(A), 13521, 13522, 13553(a), (b), 13554(a), 13556(a), 13564(a)(2), (b)(1), 13565, 13566(b), Aug. 10, 1993, 107 Stat. 578, 586, 591, 592, 607; Pub. L. 103–432, title I, §§102(g)(4), 104, 107(a), 145(b), 146(a), (b), 147(e)(1), (4), (5), (f)(3), (4)(A), (6)(A), (B), (E), 158(a)(1), Oct. 31, 1994, 108 Stat. 4404, 4405, 4407, 4427–4432, 4442; Pub. L. 104–299, §4(b)(1), Oct. 11, 1996, 110 Stat. 3645; Pub. L. 105–33, title IV, §§4102(a), (c), 4103(a), 4104(a)(1), 4105(a)(1), (b)(1), 4106(a), 4201(c)(1), (2), 4205(b)(1), (c)(1), (d)(1)–(3)(A), 4312(b)(1), (2), (d), (e), 4320, 4321(a), 4404(a), 4432(b)(5)(D), (E), 4444(a), 4445, 4446, 4451, 4454(a)(1), 4511(a)(1)–(2)(B), (d), 4512(a), 4513(a), 4522, 4531(a)(1), 4557(a), 4601(a), 4602(a)–(c), 4604(b), 4611(b), 4612(a), Aug. 5, 1997, 111 Stat. 360–362, 366, 367, 373, 376, 377, 386, 387, 394, 400, 421–426, 442–444, 450, 463, 466, 472, 474; Pub. L. 105–277, div. J, title V, §5101(a), (b), (d)(1), Oct. 21, 1998, 112 Stat. 2681–913, 2681–914; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §§201(k), 221(b)(1), 227(a), title III, §§303(a), 304(a), 321(k)(7)–(9), title V, §521], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, 1501A–351, 1501A–354, 1501A–360, 1501A–361, 1501A–367, 1501A–386; Pub. L. 106–554, §1(a)(6) [title I, §§101(a), 102(a), (b), 103(a), 105(a), (b), 112(a), 113(a), title IV, §§430(b), 431(a), title V, §§502(a), 541], Dec. 21, 2000, 114 Stat. 2763, 2763A–467, 2763A–468, 2763A–471, 2763A–473, 2763A–525, 2763A–529, 2763A–550; Pub. L. 108–173, title III, §303(i)(2), title IV, §§408(a), 414(f)(2), formerly 414(g)(2), 415(b), title V, §512(c), title VI, §§611(a), (b), (d)(2), 612(a), (b), 613(a), (b), 642(a), title VII, §§706(b), 736(a)(10), (11), (b)(3), (11), (12), (c)(4), title IX, §§901(b), 926(b)(1), 946(a), Dec. 8, 2003, 117 Stat. 2254, 2270, 2281, 2282, 2299, 2303–2305, 2322, 2339, 2355, 2356, 2374, 2396, 2424, renumbered Pub. L. 111–68, div. A, title I, §1501(e)(2), Oct. 1, 2009, 123 Stat. 2041; Pub. L. 109–171, title V, §§5004, 5112(a), (b), 5114(a)(1), (b), title VI, §6001(f)(1), Feb. 8, 2006, 120 Stat. 32, 43–45, 58; Pub. L. 110–173, title I, §114(a), Dec. 29, 2007, 121 Stat. 2501; Pub. L. 110–275, title I, §§101(a)(1), (b)(1), 125(b)(2), 143(a), (b)(5), (6), 144(a)(1), 152(b)(1)(A), (B), 153(b)(3)(B), 182(b), July 15, 2008, 122 Stat. 2496, 2497, 2519, 2542–2544, 2551, 2556, 2583; Pub. L. 110–355, §7(a), Oct. 8, 2008, 122 Stat. 3995; Pub. L. 111–148, title IV, §§4103(a), (b), 4104(a), title V, §5502(a)(1), title VI, §6402(g)(2), title X, §§10402(b), 10501(i)(1), (2)(A), Mar. 23, 2010, 124 Stat. 553, 557, 654, 759, 975, 997; Pub. L. 111–152, title I, §1301(a), (b), Mar. 30, 2010, 124 Stat. 1057; Pub. L. 112–40, title II, §261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–96, title III, §3201(a)–(c), Feb. 22, 2012, 126 Stat. 191, 192; Pub. L. 113–185, §3(a)(1), Oct. 6, 2014, 128 Stat. 1968; Pub. L. 114–10, title V, §513, Apr. 16, 2015, 129 Stat. 171; Pub. L. 114–27, title VIII, §808(a), June 29, 2015, 129 Stat. 418; Pub. L. 114–40, §2(a), July 30, 2015, 129 Stat. 441; Pub. L. 114–113, div. O, title V, §504(b)(2), Dec. 18, 2015, 129 Stat. 3022; Pub. L. 114–255, div. A, title V, §5012(a), (c)(3), Dec. 13, 2016, 130 Stat. 1198, 1202; Pub. L. 115–123, div. E, title X, §§51004, 51006(a)(1), 51008(a), (b), Feb. 9, 2018, 132 Stat. 295–297; Pub. L. 115–271, title II, §§2002(a), (b), 2005(a), (b), Oct. 24, 2018, 132 Stat. 3925, 3926, 3928; Pub. L. 116–136, div. A, title III, §§3708(c), 3713(a), Mar. 27, 2020, 134 Stat. 420, 423; Pub. L. 116–260,

div. CC, title I, §§117(a), 125(a)(1), (d)(1), title IV, §407(a)(4)(A), Dec. 27, 2020, 134 Stat. 2949, 2960, 2966, 3008.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(a)(1), (d)(1) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment notes below.

AMENDMENT OF SUBSECTIONS (eee), (fff)

Pub. L. 115–123, div. E, title X, §51008, Feb. 9, 2018, 132 Stat. 297, made amendments to subsections (eee) and (fff) of this section applicable to items and services furnished on or after Jan. 1, 2024. After such effective date—

(1) Subsection (eee)(1), (2)(A), (B), and the introductory provisions of subsection (eee)(4)(A) will read as follows:

(1) The term ''cardiac rehabilitation program'' means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

(2) A program described in this paragraph is a program under which—

(A) items and services under the program are delivered—

(i) in a physician's office;

(ii) in a hospital on an outpatient basis; or

(iii) in other settings determined appropriate by the Secretary;

(B) a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

(4)(A) The term ''intensive cardiac rehabilitation program'' means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) and has shown, in peer-reviewed published research, that it accomplished—

(2) Subsection (fff)(1) will read as follows:

(1) The term ''pulmonary rehabilitation program'' means a program (as described in subsection (eee)(2) with respect to a program under this subsection) that furnishes the items and services described in paragraph (2) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

See 2018 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (s)(10)(A), is section 4071(b) of Pub. L. 100–203, which is set out as a note below.

Section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (s)(12), is section 4072(e) of Pub. L. 100–203, which is set out as a note below.

The Public Health Service Act, referred to in subsec. (v)(1)(M), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. Titles VI and XVI of the Public Health Service Act are classified generally to subchapters IV (§291 et seq.) and XIV (§300q et seq.), respectively, of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 1395cc(a)(2)(B)(ii) of this title, referred to in subsec. (v)(4), was repealed by Pub. L. 101–239, title VI, §6017(2), Dec. 19, 1989, 103 Stat. 2165.

Section 329 of the Public Health Service Act, referred to in subsec. (aa)(2), was section 329 of act July 1, 1944, which was classified to section 254b of this title and was omitted in the general amendment of subpart I (§254b et seq.) of part D of subchapter II of chapter 6A of this title by Pub. L. 104–299, §2, Oct. 11, 1996, 110 Stat. 3626.

The Indian Self-Determination Act, referred to in subsec. (aa)(4)(D), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (aa)(4)(D), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (ss)(1)(A), is classified generally to Title 26, Internal Revenue Code.

Clause (II) of section 1395ww(d)(1)(B)(iv) of this title, referred to in subsec. (ccc)(2), was redesignated cl. (vi) of section 1395ww(d)(1)(B) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116–260, §125(a)(1)(A), inserted before period at end of concluding provisions ''or a rural emergency hospital (as defined in subsection (kkk)(2))''.

Subsec. (m). Pub. L. 116–136, §3708(c)(1)(A), in introductory provisions, inserted '', a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), or a physician assistant (as defined in subsection (aa)(5))'' after ''care of a physician'' and '', a nurse practitioner, a clinical nurse specialist, or a physician assistant'' after ''reviewed by a physician''.

Subsec. (m)(3). Pub. L. 116–136, §3708(c)(1)(B), inserted '', a nurse practitioner, a clinical nurse specialist, or a physician assistant'' after ''physician''.

Subsec. (o)(2). Pub. L. 116–136, §3708(c)(2), inserted '', nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in subsection (gg)), or physician assistants (as defined in subsection (aa)(5))'' after ''physicians'' and '', nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant,'' after ''physician''.

Subsec. (s)(10)(A). Pub. L. 116–136, §3713(a), inserted '', and COVID–19 vaccine and its administration'' after ''influenza vaccine and its administration''.

Subsec. (u). Pub. L. 116–260, §125(d)(1), inserted ''rural emergency hospital,'' after ''critical access hospital,''.

Subsec. (dd)(4)(C). Pub. L. 116–260, §407(a)(4)(A), struck out subpar. (C) which read as follows: ''Any entity that is certified as a hospice program shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agen-

cy, as determined by the Secretary, not less frequently than once every 36 months beginning 6 months after October 6, 2014, and ending September 30, 2025.''

Subsec. (kk)(1). Pub. L. 116–136, § 3708(c)(3), inserted '', nurse practitioner or clinical nurse specialist (as those terms are defined in subsection (aa)(5)), certified nurse-midwife (as defined in subsection (gg)), or physician assistant (as defined in subsection (aa)(5))'' after ''attending physician''.

Subsec. (iii)(3)(C). Pub. L. 116–260, § 117(a), inserted concluding provisions.

Subsec. (kkk). Pub. L. 116–260, § 125(a)(1)(B), added subsec. (kkk).

2018—Subsec. (s)(2)(HH). Pub. L. 115–271, § 2005(a), added subpar. (HH).

Subsec. (dd)(3)(B). Pub. L. 115–123, § 51006(a)(1), substituted '', the nurse'' for ''or nurse'' and inserted '', or the physician assistant (as defined in such subsection)'' after ''subsection (aa)(5))''.

Subsec. (ww)(1). Pub. L. 115–271, § 2002(a)(1), substituted ''paragraph (2),'' for ''paragraph (2) and'' and inserted ''and the furnishing of a review of any current opioid prescriptions (as defined in paragraph (4)),'' after ''upon the agreement with the individual,''.

Subsec. (ww)(2)(N), (O). Pub. L. 115–271, § 2002(a)(2), added subpar. (N) and redesignated former subpar. (N) as (O).

Subsec. (ww)(4). Pub. L. 115–271, § 2002(a)(3), added par. (4).

Subsec. (eee)(1). Pub. L. 115–123, § 51008(a)(1), struck out ''physician-supervised'' after ''means a'' and inserted ''under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))'' before period at end.

Subsec. (eee)(2)(A)(iii). Pub. L. 115–123, § 51008(a)(2)(A), substituted ''Secretary;'' for ''Secretary.''

Subsec. (eee)(2)(B). Pub. L. 115–123, § 51008(a)(2)(B), substituted ''a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))'' for ''a physician''.

Subsec. (eee)(4)(A). Pub. L. 115–123, § 51008(a)(3), struck out ''physician-supervised'' after '' means a'' and inserted ''under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))'' after ''paragraph (3)''.

Subsec. (eee)(4)(B)(vii), (viii). Pub. L. 115–123, § 51004, added cls. (vii) and (viii).

Subsec. (fff)(1). Pub. L. 115–123, § 51008(b), struck out ''physician-supervised'' after ''means a'' and inserted ''under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))'' before period at end.

Subsec. (hhh)(2)(G) to (I). Pub. L. 115–271, § 2002(b), added subpars. (G) and (H) and redesignated former subpar. (G) as (I).

Subsec. (jjj). Pub. L. 115–271, § 2005(b), added subsec. (jjj).

2016—Subsec. (m). Pub. L. 114–255, § 5012(c)(3), inserted ''and home infusion therapy (as defined in subsection (iii)(i))'' after ''furnished to an inpatient of a hospital'' in concluding provisions.

Subsec. (s)(2)(GG). Pub. L. 114–255, § 5012(a)(1), added subpar. (GG).

Subsec. (iii). Pub. L. 114–255, § 5012(a)(2), added subsec. (iii).

2015—Subsec. (m)(5). Pub. L. 114–113, § 504(b)(2), inserted ''and applicable disposable devices (as defined in section 1395m(s)(2) of this title)'' after ''durable medical equipment''.

Subsec. (n). Pub. L. 114–40 inserted ''and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories'' after ''appropriate organizations)''.

Subsec. (*o*)(7). Pub. L. 114–10 amended par. (7) generally. Prior to amendment, par. (7) read as follows:

''(7) provides the Secretary with a surety bond—

''(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

''(B) in a form specified by the Secretary; and

''(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this subchapter and subchapter XIX of this chapter for that year, as estimated by the Secretary that the Secretary determines is commensurate with the volume of the billing of the home health agency; and''.

Subsec. (s)(2)(F). Pub. L. 114–27 inserted before semicolon at end '', including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1395rr(b)(14) of this title to an individual with acute kidney injury (as defined in section 1395m(r)(2) of this title)''.

2014—Subsec. (dd)(4)(C). Pub. L. 113–185 added subpar. (C).

2012—Subsec. (v)(1)(T)(iv), (v). Pub. L. 112–96, § 3201(a), substituted ''fiscal years 2001 through 2012'' for ''a subsequent fiscal year'' in cl. (iv) and added cl. (v).

Subsec. (v)(1)(V). Pub. L. 112–96, § 3201(b)(1), substituted ''and (beginning with respect to cost reporting periods beginning during fiscal year 2013) for covered skilled nursing services described in section 1395yy(e)(2)(A) of this title furnished by hospital providers of extended care services (as described in section 1395tt of this title)'' for ''with respect to cost reporting periods beginning on or after October 1, 2005'' in introductory provisions.

Subsec. (v)(1)(V)(i). Pub. L. 112–96, § 3201(b)(2), substituted ''reduced by—'' for ''reduced by 30 percent of such amount otherwise allowable; and'' and added subcls. (I) and (II).

Subsec. (v)(1)(V)(ii). Pub. L. 112–96, § 3201(b)(3), substituted ''such section—'' for ''such section shall not be reduced.'' and added subcls. (I) to (IV).

Subsec. (v)(1)(W). Pub. L. 112–96, § 3201(c), added subpar. (W).

2011—Subsecs. (v)(1)(G)(i), (w)(2). Pub. L. 112–40 substituted ''quality improvement'' for ''quality control and peer review''.

2010—Subsec. (*o*)(7)(C). Pub. L. 111–148, § 6402(g)(2), which directed amendment by inserting ''that the Secretary determines is commensurate with the volume of the billing of the home health agency'' before semicolon ''at the end'', was executed by making the insertion before ''; and'' to reflect the probable intent of Congress.

Subsec. (s)(2)(K). Pub. L. 111–148, § 4103(a)(2), substituted ''subsections (ww)(1) and (hhh)'' for ''subsection (ww)(1)'' in cls. (i) and (ii).

Subsec. (s)(2)(FF). Pub. L. 111–148, § 4103(a)(1), added subpar. (FF).

Subsec. (aa)(3)(A). Pub. L. 111–148, § 10501(i)(2)(A), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''services of the type described in subparagraphs (A) through (C) of paragraph (1) and services described in subsections (qq) and (vv); and''.

Pub. L. 111–148, § 5502(a)(1), which directed general amendment of subpar. (A), was repealed by Pub. L. 111–148, § 10501(i)(1).

Subsec. (ff)(3)(A). Pub. L. 111–152, § 1301(b), inserted ''other than in an individual's home or in an inpatient or residential setting'' before period at end.

Subsec. (ff)(3)(B)(iii), (iv). Pub. L. 111–152, § 1301(a), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (ddd). Pub. L. 111–148, § 4104(a)(1), inserted ''; preventive services'' after ''services'' in heading.

Subsec. (ddd)(1). Pub. L. 111–148, § 4104(a)(2), substituted ''not described in subparagraph (A) or (C) of

paragraph (3)'' for ''not otherwise described in this subchapter''.

Subsec. (ddd)(3). Pub. L. 111–148, §4104(a)(3), added par. (3).

Subsec. (hhh). Pub. L. 111–148, §4103(b), added subsec. (hhh).

Subsec. (hhh)(4)(G). Pub. L. 111–148, §10402(b), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows:

''(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under part B of this subchapter and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

''(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary's coverage begins under part B of this subchapter, which shall include information regarding any relevant differences between such services.''

2008—Subsec. (e). Pub. L. 110–275, §125(b)(2), in third sentence after par. (9), substituted ''and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1395bb(a) of this title, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body.'' for ''and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals''.

Subsec. (p). Pub. L. 110–275, §143(b)(5), struck out third sentence in concluding provisions, which read as follows: ''The term 'outpatient physical therapy services' also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.''

Subsec. (s)(2)(D). Pub. L. 110–275, §143(b)(6), inserted '', outpatient speech-language pathology services,'' after ''physical therapy services''.

Subsec. (s)(2)(F). Pub. L. 110–275, §153(b)(3)(B), inserted '', and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title)'' before semicolon at end.

Subsec. (s)(2)(BB). Pub. L. 110–275, §101(a)(1)(A), added subpar. (BB).

Subsec. (s)(2)(CC), (DD). Pub. L. 110–275, §144(a)(1)(A), added subpars. (CC) and (DD).

Subsec. (s)(2)(EE). Pub. L. 110–275, §152(b)(1)(A), added subpar. (EE).

Subsec. (t)(2)(B). Pub. L. 110–275, §182(b), in concluding provisions, inserted ''On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.'' at end.

Subsec. (aa)(2). Pub. L. 110–355 substituted ''4-year period'' for ''3-year period'' in cl. (i) of concluding provisions.

Subsec. (*ll*)(2) to (4). Pub. L. 110–275, §143(a), added par. (2) and redesignated former pars. (2) and (3) as (3) and (4), respectively.

Subsec. (ww)(1). Pub. L. 110–275, §101(b)(1)(A), inserted ''body mass index,'' after ''weight'', struck out '', and an electrocardiogram'' after ''blood pressure'', and inserted ''and end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual'' after ''paragraph (2)''.

Subsec. (ww)(2)(M), (N). Pub. L. 110–275, §101(b)(1)(B), added subpars. (M) and (N).

Subsec. (ww)(3). Pub. L. 110–275, §101(b)(1)(C), added par. (3).

Subsec. (ddd). Pub. L. 110–275, §101(a)(1)(B), added subsec. (ddd).

Subsecs. (eee), (fff). Pub. L. 110–275, §144(a)(1)(B), added subsecs. (eee) and (fff).

Subsec. (ggg). Pub. L. 110–275, §152(b)(1)(B), added subsec. (ggg).

2007—Subsec. (ccc). Pub. L. 110–173 added subsec. (ccc).

2006—Subsec. (s)(2)(AA). Pub. L. 109–171, §5112(a)(1), added subpar. (AA).

Subsec. (t)(2)(B)(ii)(I). Pub. L. 109–171, §6001(f)(1), inserted ''(or its successor publications)'' after ''United States Pharmacopoeia-Drug Information''.

Subsec. (v)(1)(T). Pub. L. 109–171, §5004(b), substituted ''section 1395*l*(t)(8)(B)'' for ''section 1395*l*(t)(5)(B)'' in introductory provisions.

Subsec. (v)(1)(V). Pub. L. 109–171, §5004(a), added subpar. (V).

Subsec. (aa)(3). Pub. L. 109–171, §5114(a)(1), substituted ''and services described in subsections (qq) and (vv); and'' for '', and'' in subpar. (A) and ''section 330'' for ''sections 329, 330, and 340'' in subpar. (B) and inserted ''by the center or by a health care professional under contract with the center'' after ''outpatient of a Federally qualified health center'' in concluding provisions.

Subsec. (aa)(4)(A)(i), (ii)(II). Pub. L. 109–171, §5114(b), struck out ''(other than subsection (h))'' after ''section 330''.

Subsec. (ww)(2)(L). Pub. L. 109–171, §5112(b), added subpar. (L).

Subsec. (bbb). Pub. L. 109–171, §5112(a)(2), added subsec. (bbb).

2003—Subsec. (d). Pub. L. 108–173, §901(b), added subsec. (d).

Subsec. (s)(2)(A). Pub. L. 108–173, §303(i)(2), inserted ''(or would have been so included but for the application of section 1395w–3b of this title)'' after ''included in the physicians' bills''.

Subsec. (s)(2)(K)(i). Pub. L. 108–173, §736(b)(11), substituted '', but'' for ''; and but''.

Pub. L. 108–173, §611(d)(2), inserted ''and services described in subsection (ww)(1)'' after ''services which would be physicians' services''.

Subsec. (s)(2)(K)(ii). Pub. L. 108–173, §611(d)(2), inserted ''and services described in subsection (ww)(1)'' after ''services which would be physicians' services''.

Subsec. (s)(2)(W). Pub. L. 108–173, §611(a), added subpar. (W).

Subsec. (s)(2)(X). Pub. L. 108–173, §612(a), added subpar. (X).

Subsec. (s)(2)(Y). Pub. L. 108–173, §613(a), added subpar. (Y).

Subsec. (s)(2)(Z). Pub. L. 108–173, §642(a)(1), added subpar. (Z).

Subsec. (s)(7). Pub. L. 108–173, §415(b), inserted '', subject to section 1395m(*l*)(14) of this title,'' after ''but''.

Subsec. (v)(1)(S)(ii)(III). Pub. L. 108–173, §736(b)(3), inserted closing parenthesis after ''as defined in section 1395ww(d)(5)(D)(iii) of this title''.

Subsec. (v)(1)(U). Pub. L. 108–173, §414(f)(2), formerly §414(g)(2), as renumbered by Pub. L. 111–68, realigned margins.

Subsec. (v)(8). Pub. L. 108–173, §736(c)(4), realigned margins.

Subsec. (aa)(1)(B). Pub. L. 108–173, §736(b)(12), struck out second comma after ''(as defined in subsection (hh)(1)),''.

Subsec. (dd)(2)(A)(i). Pub. L. 108–173, §512(c), inserted ''and services described in section 1395d(a)(5) of this title'' before comma at end.

Subsec. (dd)(3)(B). Pub. L. 108–173, §408(a), inserted ''or nurse practitioner (as defined in subsection (aa)(5))'' after ''the physician (as defined in subsection (r)(1))''.

Subsec. (dd)(5)(D), (E). Pub. L. 108–173, §946(a), added subpars. (D) and (E).

Subsec. (ee)(2)(D). Pub. L. 108–173, §926(b)(1), substituted ''hospice care and post-hospital extended care services'' for ''hospice services'' and inserted before period at end ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides''.

Subsec. (mm). Pub. L. 108–173, §736(a)(10), made technical amendment to heading.

Subsec. (tt)(1)(A), (2)(B). Pub. L. 108–173, §736(a)(11), substituted ''critical access hospital'' for ''rural primary care hospital''.

Subsec. (ww). Pub. L. 108–173, §611(b), added subsec. (ww).

Subsec. (xx). Pub. L. 108–173, §612(b), added subsec. (xx).

Subsec. (yy). Pub. L. 108–173, §613(b), added subsec. (yy).

Subsec. (zz). Pub. L. 108–173, §642(a)(2), added subsec. (zz).

Subsec. (aaa). Pub. L. 108–173, §706(b), added subsec. (aaa).

2000—Subsec. (s)(2)(A), (B). Pub. L. 106–554, §1(a)(6) [title I, §112(a)], substituted ''(including drugs and biologicals which are not usually self-administered by the patient)'' for ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)''.

Subsec. (s)(2)(J). Pub. L. 106–554, §1(a)(6) [title I, §113(a)], struck out provisions limiting application to drugs furnished within 12 months after the date of the transplant procedure for drugs furnished before 1995, to within 18 months after the date of the transplant procedure for drugs furnished during 1995, to within 24 months after the date of the transplant procedure for drugs furnished during 1996, to within 30 months after the date of the transplant procedure for drugs furnished during 1997, and to within 36 months after the date of the transplant procedure plus additional number of months provided under section 1395k(b) for drugs furnished during any year after 1997.

Subsec. (s)(2)(U). Pub. L. 106–554, §1(a)(6) [title I, §102(a)], added subpar. (U).

Subsec. (s)(2)(V). Pub. L. 106–554, §1(a)(6) [title I, §105(a)], added subpar. (V).

Subsec. (t)(1). Pub. L. 106–554, §1(a)(6) [title IV, §430(b)], inserted ''(including contrast agents)'' after ''only such drugs''.

Subsec. (v)(1)(L)(x). Pub. L. 106–554, §1(a)(6) [title V, §502(a)], struck out ''2001,'' after ''2000,'' and inserted at end ''With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.''

Subsec. (v)(1)(T)(ii). Pub. L. 106–554, §1(a)(6) [title V, §541(1)], struck out ''and'' at end.

Subsec. (v)(1)(T)(iii). Pub. L. 106–554, §1(a)(6) [title V, §541(2)], substituted ''during fiscal year 2000'' for ''during a subsequent fiscal year'' and '', and'' for period at end.

Subsec. (v)(1)(T)(iv). Pub. L. 106–554, §1(a)(6) [title V, §541(3)], added cl. (iv).

Subsec. (ff)(3)(B). Pub. L. 106–554, §1(a)(6) [title IV, §431(a)], substituted ''entity that—'' for ''entity—'', added cls. (i) to (iii), and struck out former cls. (i) and (ii) which read as follows:

''(i) providing the services described in section 1916(c)(4) of the Public Health Service Act; and

''(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located.''

Subsec. (nn)(1), (2). Pub. L. 106–554, §1(a)(6) [title I, §101(a)], substituted ''2 years'' for ''3 years''.

Subsec. (pp)(1)(C). Pub. L. 106–554, §1(a)(6) [title I, §103(a)(1)], substituted ''Screening colonoscopy'' for ''In the case of an individual at high risk for colorectal cancer, screening colonoscopy''.

Subsec. (pp)(2). Pub. L. 106–554, §1(a)(6) [title I, §103(a)(2)], substituted ''An'' for ''In paragraph (1)(C), an''.

Subsec. (uu). Pub. L. 106–554, §1(a)(6) [title I, §102(b)], added subsec. (uu).

Subsec. (vv). Pub. L. 106–554, §1(a)(6) [title I, §105(b)], added subsec. (vv).

1999—Subsec. (*o*)(7). Pub. L. 106–113, §1000(a)(6) [title III, §304(a)], amended par. (7) generally. Prior to amendment, par. (7) read as follows: ''provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and''.

Subsec. (p)(1). Pub. L. 106–113, §1000(a)(6) [title II, §221(b)(1)(A)], substituted '', (3), or (4)'' for ''or (3)''.

Subsec. (r)(4). Pub. L. 106–113, §1000(a)(6) [title II, §221(b)(1)(B)], inserted ''for purposes of subsection (p)(1) and'' after ''but only''.

Subsec. (s)(2)(J)(v). Pub. L. 106–113, §1000(a)(6) [title II, §227(a)], inserted before semicolon at end ''plus such additional number of months (if any) provided under section 1395k(b) of this title''.

Subsec. (s)(2)(T)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(7)], substituted semicolon for period at end.

Subsec. (v)(1)(L)(ix), (x). Pub. L. 106–113, §1000(a)(6) [title III, §303(a)], added cl. (ix) and redesignated former cl. (ix) as (x).

Subsec. (v)(1)(S)(ii)(I), (II). Pub. L. 106–113, §1000(a)(6) [title II, §201(k)], substituted ''and until the first date that the prospective payment system under section 1395*l*(t) of this title is implemented'' for ''and during fiscal year 2000 before January 1, 2000''.

Subsec. (aa)(2)(I). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(8)], substituted semicolon for comma at end and realigned margins.

Subsec. (ee)(3). Pub. L. 106–113, §1000(a)(6) [title V, §521], added par. (3).

Subsec. (ss)(1)(G)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(9)(B)], which directed substitution of ''or'' for ''of'', was executed by making the substitution for ''of'' the second time appearing to reflect the probable intent of Congress.

Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(9)(A)], substituted ''owned'' for ''owed''.

1998—Subsec. (v)(1)(L)(i)(III) to (V). Pub. L. 105–277, §5101(b), in subcl. (III) struck out ''or'' at end, in subcl. (IV) inserted ''and before October 1, 1998,'' after ''1997,'' and substituted '', or'' for period at end, and added subcl. (V).

Subsec. (v)(1)(L)(v). Pub. L. 105–277, §5101(a)(1), inserted ''subject to clause (viii)(I),'' before ''the Secretary'' in introductory provisions.

Subsec. (v)(1)(L)(vi)(I). Pub. L. 105–277, §5101(a)(2), inserted ''subject to clauses (viii)(II) and (viii)(III)'' after ''1994''.

Subsec. (v)(1)(L)(viii). Pub. L. 105–277, §5101(a)(3), added cl. (viii).

Subsec. (v)(1)(L)(ix). Pub. L. 105–277, §5101(d)(1), added cl. (ix).

1997—Subsec. (a). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' in pars. (1) and (2).

Subsec. (b)(4). Pub. L. 105–33, §4511(a)(2)(B), substituted ''subsection (s)(2)(K)'' for ''clauses (i) or (iii) of subsection (s)(2)(K)''.

Subsec. (e). Pub. L. 105–33, §4454(a)(1)(A), in fifth sentence after par. (9), substituted ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'' for ''includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts,'' and inserted ''consistent with section 1395i–5 of this title'' before the period.

Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' in last sentence.

Subsec. (h). Pub. L. 105–33, §4432(b)(5)(D)(i), substituted ''paragraphs (3), (6), and (7)'' for ''paragraphs (3) and (6)'' in introductory provisions.

Subsec. (h)(7). Pub. L. 105–33, §4432(b)(5)(D)(ii), inserted '', or by others under arrangements with them made by the facility'' after ''skilled nursing facilities''.

Subsec. (m). Pub. L. 105–33, §4612(a), inserted at end of closing provisions ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''

Subsec. (n). Pub. L. 105–33, §4105(b)(1), inserted before semicolon in first sentence '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

Subsec. (*o*). Pub. L. 105–33, §4312(b)(1)(D), inserted at end of closing provisions ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''

Subsec. (*o*)(7), (8). Pub. L. 105–33, §4312(b)(1)(A)–(C), added par. (7) and redesignated former par. (7) as (8).

Subsec. (p). Pub. L. 105–33, §4312(e)(2), inserted at end of closing provisions ''The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''

Subsec. (p)(4)(A)(v). Pub. L. 105–33, §4312(e)(1), inserted ''and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'' after ''as the Secretary may find necessary,''.

Subsec. (r)(5). Pub. L. 105–33, §4513(a), struck out ''demonstrated by x-ray to exist'' following ''(to correct a subluxation''.

Subsec. (s)(2)(K)(i). Pub. L. 105–33, §§4511(a)(2)(A)(i), 4512(a), struck out ''(I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1396r(a) of this title), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health professional shortage area,'' after ''physician (as so defined)'' and inserted at end ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

Subsec. (s)(2)(K)(ii). Pub. L. 105–33, §4511(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) in a skilled nursing facility or nursing facility (as defined in section 1396r(a) of this title) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,''.

Subsec. (s)(2)(K)(iii), (iv). Pub. L. 105–33, §4511(a)(2)(A)(ii), struck out cls. (iii) and (iv) which read as follows:

''(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and

''(iv) such services and supplies furnished as an incident to services described in clause (i) or (ii) as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;''.

Subsec. (s)(2)(N) to (P). Pub. L. 105–33, §4103(a)(1), struck out ''and'' at end of subpars. (N) and (O) and added subpar. (P).

Subsec. (s)(2)(R). Pub. L. 105–33, §4104(a)(1)(A), added subpar. (R).

Subsec. (s)(2)(S). Pub. L. 105–33, §4105(a)(1)(A), added subpar. (S).

Subsec. (s)(2)(T). Pub. L. 105–33, §4557(a), added subpar. (T).

Subsec. (s)(12)(C). Pub. L. 105–33, §4106(a)(1)(A), struck out ''and'' at end.

Subsec. (s)(14). Pub. L. 105–33, §4102(c), inserted ''and screening pelvic exam'' after ''screening pap smear''.

Subsec. (s)(15) to (17). Pub. L. 105–33, §4106(a)(1)(B)–(D), added par. (15) and redesignated former pars. (15) and (16) as (16) and (17), respectively.

Subsec. (u). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (v)(1)(H)(i). Pub. L. 105–33, §4312(b)(2)(A), substituted ''the surety bond requirement described in subsection (*o*)(7) and the financial security requirement described in subsection (*o*)(8)'' for ''the financial security requirement described in subsection (*o*)(7)''.

Subsec. (v)(1)(H)(ii). Pub. L. 105–33, §4312(b)(2)(B), substituted ''the surety bond requirement described in subsection (*o*)(7) and the financial security requirement described in subsection (*o*)(8) apply'' for ''the financial security requirement described in subsection (*o*)(7) applies''.

Subsec. (v)(1)(L)(i). Pub. L. 105–33, §4602(a)(5), struck out closing provisions which read as follows: ''of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.''

Subsec. (v)(1)(L)(i)(I). Pub. L. 105–33, §4602(a)(1), (2), inserted ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before comma at end and realigned margins.

Subsec. (v)(1)(L)(i)(II). Pub. L. 105–33, §4602(a)(1), (3), substituted ''of such mean,'' for '', or'' at end and realigned margins.

Subsec. (v)(1)(L)(i)(III). Pub. L. 105–33, §4602(a)(1), (4), inserted ''and before October 1, 1997,'' after ''July 1, 1987,'', substituted ''of such mean, or'' for comma at end, and realigned margins.

Subsec. (v)(1)(L)(i)(IV). Pub. L. 105–33, §4602(a)(5), added subcl. (IV).

Subsec. (v)(1)(L)(iii). Pub. L. 105–33, §4604(b), substituted ''service is furnished'' for ''agency is located''.

Pub. L. 105–33, §4602(b), inserted '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

Subsec. (v)(1)(L)(iv). Pub. L. 105–33, §4601(a), added cl. (iv).

Subsec. (v)(1)(L)(v) to (vii). Pub. L. 105–33, §4602(c), added cls. (v) to (vii).

Subsec. (v)(1)(O)(i). Pub. L. 105–33, §4404(a)(1), struck out ''and (if applicable) a return on equity capital'' after ''capital indebtedness'' and substituted ''provider of services'' for ''hospital or skilled nursing facility'', ''clause (iii)'' for ''clause (iv)'', and ''the historical cost of the asset, as recognized under this subchapter, less depreciation allowed, to the owner of record as of August 5, 1997 (or, in the case of an asset not in existence as of August 5, 1997, the first owner of record of the asset after August 5, 1997).'' for ''the lesser of the allow-

able acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.''

Subsec. (v)(1)(O)(ii) to (iv). Pub. L. 105–33, § 4404(a)(2), (3), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: ''Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984.''

Subsec. (v)(1)(S)(ii)(I), (II). Pub. L. 105–33, § 4522, substituted ''through 1999 and during fiscal year 2000 before January 1, 2000'' for ''through 1998''.

Subsec. (v)(1)(S)(ii)(III). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (v)(1)(T). Pub. L. 105–33, § 4451, added subpar. (T).

Subsec. (v)(1)(U). Pub. L. 105–33, § 4531(a)(1), added subpar. (U).

Subsec. (v)(7)(D). Pub. L. 105–33, § 4432(b)(5)(E), inserted ''subsections (a) through (c) of'' before ''section 1395yy of this title''.

Subsec. (v)(8). Pub. L. 105–33, § 4320, added par. (8).

Subsec. (w). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care'' wherever appearing.

Subsec. (y). Pub. L. 105–33, § 4454(a)(1)(B)(i), substituted ''Extended care in religious nonmedical health care institutions'' for ''Post-hospital extended care in Christian Science skilled nursing facilities'' in heading.

Subsec. (y)(1). Pub. L. 105–33, § 4454(a)(1)(B)(iii), which directed the amendment of this subsec. by inserting ''consistent with section 1395i–5 of this title'' before the period, was executed by making the insertion in par. (1) to reflect the probable intent of Congress.

Pub. L. 105–33, § 4454(a)(1)(B)(ii), substituted ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'' for ''includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts,''.

Subsec. (aa)(2). Pub. L. 105–33, § 4205(d)(3)(A), in second sentence of concluding provisions inserted before period at end ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

Pub. L. 105–33, § 4205(d)(1), (2), in cl. (i) of first sentence of concluding provisions substituted ''Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 3-year period, has been designated'' for ''Bureau of the Census) and that is designated'' and ''personal health services or designated by the Secretary'' for ''personal health services, or that is designated by the Secretary''.

Subsec. (aa)(2)(I). Pub. L. 105–33, § 4205(b)(1), amended subpar. (I) generally. Prior to amendment, subpar. (I) read as follows: ''has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible;''.

Subsec. (aa)(5). Pub. L. 105–33, § 4511(d), designated existing provisions as subpar. (A), substituted ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs'' for ''The term 'physician assistant', the term 'nurse practitioner', and the term 'clinical nurse specialist' mean, for purposes of this subchapter, a physician assistant, nurse practitioner, or clinical nurse specialist who performs'', and added subpar. (B).

Subsec. (aa)(7)(B). Pub. L. 105–33, § 4205(c)(1), inserted before period at end '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic''.

Subsec. (cc)(2). Pub. L. 105–33, § 4312(d)(4), inserted concluding provisions.

Subsec. (cc)(2)(I), (J). Pub. L. 105–33, § 4312(d)(1)–(3), added subpar. (I) and redesignated former subpar. (I) as (J).

Subsec. (dd)(1)(I). Pub. L. 105–33, § 4444(a), added subpar. (I).

Subsec. (dd)(2)(A)(ii)(I). Pub. L. 105–33, § 4445(1), substituted ''subparagraphs (A), (C), and (H)'' for ''subparagraphs (A), (C), (F), and (H)''.

Subsec. (dd)(2)(B)(i). Pub. L. 105–33, § 4445(2), in concluding provisions, inserted ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

Subsec. (dd)(5)(B). Pub. L. 105–33, § 4446(1), inserted ''or (C)'' after ''subparagraph (A)'' in two places.

Subsec. (dd)(5)(C). Pub. L. 105–33, § 4446(2), added subpar. (C).

Subsec. (ee)(2)(D). Pub. L. 105–33, § 4321(a)(1), inserted before period at end '', including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available''.

Subsec. (ee)(2)(H). Pub. L. 105–33, § 4321(a)(2), added subpar. (H).

Subsec. (mm). Pub. L. 105–33, § 4201(c)(2), amended heading and text of subsec. (mm) generally. Prior to amendment, text read as follows:

''(1) The term 'rural primary care hospital' means a facility designated by the Secretary as a rural primary care hospital under section 1395i–4(i)(2) of this title.

''(2) The term 'inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient rural primary care hospital services' means medical and other health services furnished by a rural primary care hospital.''

Subsec. (nn). Pub. L. 105–33, § 4102(a), substituted ''Screening pap smear; screening pelvic exam'' for ''Screening pap smear'' in heading, designated existing provisions as par. (1), inserted ''or vaginal'' after ''cervical'' in two places, substituted ''3 years, or during the preceding year in the case of a woman described in paragraph (3).'' for ''3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary)).'', and added pars. (2) and (3).

Subsec. (*oo*). Pub. L. 105–33, § 4103(a)(2), added subsec. (*oo*).

Subsec. (pp). Pub. L. 105–33, § 4104(a)(1)(B), added subsec. (pp).

Subsec. (qq). Pub. L. 105–33, § 4105(a)(1)(B), added subsec. (qq).

Subsec. (rr). Pub. L. 105–33, § 4106(a)(2), added subsec. (rr).

Subsec. (ss). Pub. L. 105–33, § 4454(a)(1)(C), added subsec. (ss).

Subsec. (tt). Pub. L. 105–33, § 4611(b), added subsec. (tt).

1996—Subsec. (aa)(4)(A)(i). Pub. L. 104–299 substituted ''section 330 (other than subsection (h))'' for ''section 329, 330, or 340''.

Subsec. (aa)(4)(A)(ii)(II). Pub. L. 104–299 which directed amendment of subcl. (I) by substituting ''section 330 (other than subsection (h))'' for ''section 329, 330, or 340'', was executed to subcl. (II) to reflect the probable intent of Congress.

1994—Subsec. (a)(1). Pub. L. 103–432, § 102(g)(4)(A), substituted ''inpatient hospital services, inpatient rural primary care hospital services'' for ''inpatient hospital services''.

Subsec. (a)(2). Pub. L. 103–432, § 102(g)(4)(B), substituted ''hospital or rural primary care hospital'' for ''hospital''.

Subsec. (b)(3). Pub. L. 103–432, § 147(f)(3), made technical amendment to Pub. L. 101–508, § 4157(a). See 1990 Amendment note below.

Subsec. (b)(4). Pub. L. 103–432, § 147(f)(3), made technical amendment to Pub. L. 101–508, § 4157(a). See 1990 Amendment note below.

Pub. L. 103–432, §147(e)(4), substituted ''clauses (i) or (iii) of subsection (s)(2)(K)'' for ''subsection (s)(2)(K)(i)''.

Subsec. (e)(4). Pub. L. 103–432, §104, substituted ''physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;'' for ''physician;''.

Subsec. (h)(3). Pub. L. 103–432, §146(b)(1), substituted ''or occupational therapy or speech-language pathology services'' for '', occupational, or speech therapy''.

Subsec. (m)(2). Pub. L. 103–432, §146(b)(2), substituted ''or occupational therapy or speech-language pathology services'' for '', occupational, or speech therapy''.

Subsec. (m)(5). Pub. L. 103–432, §147(f)(6)(B)(ii), substituted ''and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs'' for ''but excluding drugs''.

Subsec. (p). Pub. L. 103–432, §146(b)(3), substituted ''speech-language pathology services'' for ''speech pathology services'' after ''term 'outpatient physical therapy services' also includes'' in third sentence of closing provisions.

Subsec. (s)(2)(K)(iii). Pub. L. 103–432, §147(e)(1), made an amendment identical to that made by Pub. L. 101–508, §4161(a)(5)(A), substituting ''subsection (aa)(5)'' for ''subsection (aa)(3)'' and ''subsection (aa)(6)'' for ''subsection (aa)(4)''.

Subsec. (s)(2)(N). Pub. L. 103–432, §147(f)(6)(B)(iii)(I), inserted ''and'' at end.

Subsec. (s)(2)(O), (P). Pub. L. 103–432, §147(f)(6)(B)(iii)(II), redesignated subpar. (P) as (O) and struck out former subpar. (O) which read as follows: ''a covered osteoporosis drug and its administration (as defined in subsection (jj) of this section) furnished on or after January 1, 1991, and on or before December 31, 1995; and''.

Subsec. (s)(3). Pub. L. 103–432, §145(b), inserted ''and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act'' after ''necessary''.

Subsec. (v)(1)(L)(iii). Pub. L. 103–432, §158(a)(1), substituted ''and determined using the survey of the most recent available wages and wage-related costs of hospitals'' for ''as of such date to hospitals''.

Subsec. (aa)(2). Pub. L. 103–432, §147(f)(4)(A), in last sentence of closing provisions, substituted ''approval as such a clinic'' for ''certification as such a clinic'' and ''Secretary's approval or disapproval'' for ''the Secretary's approval or disapproval of the certification''.

Subsec. (aa)(5). Pub. L. 103–432, §147(e)(5), substituted ''this subchapter'' for ''this chapter''.

Subsec. (cc)(1)(B). Pub. L. 103–432, §146(b)(4), substituted ''speech-language pathology services'' for ''speech pathology services''.

Subsec. (dd)(1)(B). Pub. L. 103–432, §146(b)(5), substituted ''therapy, or speech-language pathology services'' for ''therapy or speech-language pathology''.

Subsec. (ee)(2)(D). Pub. L. 103–432, §107(a), inserted '', including hospice services,'' after ''post-hospital services''.

Subsec. (jj). Pub. L. 103–432, §147(f)(6)(E), redesignated subsec. (jj), defining ''covered osteoporosis drug'', as (kk).

Pub. L. 103–432, §147(f)(6)(A), (B)(i), amended subsec. (jj), defining ''covered osteoporosis drug'', in introductory provisions, by striking out ''a bone fracture related to'' before ''post-menopausal osteoporosis'' and substituting ''individual by a home health agency if'' for ''individual if'', and in par. (1), by substituting ''individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual'' for ''patient''.

Subsec. (kk). Pub. L. 103–432, §147(f)(6)(E), redesignated subsec. (jj), defining ''covered osteoporosis drug'', as (kk).

Subsec. (*ll*). Pub. L. 103–432, §146(a), added subsec. (*ll*).

1993—Subsec. (s)(2)(J). Pub. L. 103–66, §13565, substituted ''subchapter, but only in the case of drugs furnished—'' and cls. (i) to (v) for ''subchapter, within 1 year after the date of the transplant procedure;''.

Subsec. (s)(2)(P). Pub. L. 103–66, §13566(b), substituted ''dialysis'' for ''home dialysis'' and realigned margin.

Subsec. (s)(2)(Q). Pub. L. 103–66, §13553(a), added subpar. (Q).

Subsec. (t). Pub. L. 103–66, §13553(b), designated existing provisions as par. (1), inserted ''and paragraph (2)'', and added par. (2).

Subsec. (v)(1)(B). Pub. L. 103–66, §13503(c)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any cost reporting period shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.''

Subsec. (v)(1)(L)(ii). Pub. L. 103–66, §13564(b)(1), struck out '', with appropriate adjustment for administrative and general costs of hospital-based agencies'' after ''discipline specific basis''.

Subsec. (v)(1)(L)(iii). Pub. L. 103–66, §13564(a)(2), substituted ''thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996)'' for ''thereafter''.

Subsec. (v)(1)(S)(ii)(I). Pub. L. 103–66, §13521, substituted ''fiscal years 1992 through 1998'' for ''fiscal year 1992, 1993, 1994, or 1995''.

Subsec. (v)(1)(S)(ii)(II). Pub. L. 103–66, §13522, substituted ''fiscal years 1991 through 1998'' for ''fiscal years 1991, 1992, 1993, 1994, or 1995''.

Subsec. (aa)(4)(D). Pub. L. 103–66, §13556(a), added subpar. (D).

Subsec. (gg)(2). Pub. L. 103–66, §13554(a), substituted a period for '', and performs services in the area of management of the care of mothers and babies throughout the maternity cycle.''

1990—Subsec. (b)(3). Pub. L. 101–508, §4157(a)(1), as amended by Pub. L. 103–432, §147(f)(3), struck out ''(including clinical psychologist (as defined by the Secretary))'' after ''the hospital or by others''.

Subsec. (b)(4). Pub. L. 101–508, §4157(a)(2), as amended by Pub. L. 103–432, §147(f)(3), substituted '', services described by subsection (s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and'' for ''and anesthesia services provided by a certified registered nurse anesthetist; and''.

Subsec. (n). Pub. L. 101–508, §4152(a)(2), inserted at end ''With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.''

Subsec. (s)(2)(E). Pub. L. 101–508, §4161(a)(1), inserted ''and Federally qualified health center services'' after ''clinic services''.

Subsec. (s)(2)(H)(i). Pub. L. 101–508, §4161(a)(5)(A), substituted ''subsection (aa)(5)'' for ''subsection (aa)(3)''.

Subsec. (s)(2)(K)(i). Pub. L. 101–597 substituted ''health professional shortage area'' for ''health manpower shortage area''.

Pub. L. 101–508, §4161(a)(5)(A), substituted ''subsection (aa)(5)'' for ''subsection (aa)(3)''.

Subsec. (s)(2)(K)(ii). Pub. L. 101–508, §4161(a)(5)(A), substituted ''subsection (aa)(5)'' for ''subsection (aa)(3)'' and ''subsection (aa)(6)'' for ''subsection (aa)(4)''.

Subsec. (s)(2)(K)(iii). Pub. L. 101–508, §4161(a)(5)(A), substituted ''subsection (aa)(5)'' for ''subsection (aa)(3)'' and ''subsection (aa)(6)'' for ''subsection (aa)(4)''.

Pub. L. 101–508, §4155(a)(3), added cl. (iii). Former cl. (iii) redesignated (iv).

Subsec. (s)(2)(K)(iv). Pub. L. 101–508, § 4155(a)(2), redesignated cl. (iii) as (iv).

Subsec. (s)(2)(O). Pub. L. 101–508, § 4156(a)(1), added subpar. (O).

Subsec. (s)(2)(P). Pub. L. 101–508, § 4201(d)(1), added subpar. (P).

Subsec. (s)(8). Pub. L. 101–508, § 4153(b)(2)(A), inserted '', and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens'' after ''such devices''.

Subsec. (s)(13). Pub. L. 101–508, § 4163(a)(1), added par. (13).

Subsec. (v)(1)(E). Pub. L. 101–508, § 4008(h)(2)(A)(i), substituted ''the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of such facilities'' for ''the costs of such facilities'' in second sentence.

Subsec. (v)(1)(L)(iii). Pub. L. 101–508, § 4207(d)(1), formerly § 4027(d)(1), as renumbered by Pub. L. 103–432, § 160(d)(4), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: ''In establishing limits under this subparagraph, the Secretary shall—

''(I) utilize a wage index that is based on verified wage data obtained from home health agencies, and

''(II) base such limits on the most recent verified wage data available, which data may be for cost reporting periods beginning no earlier than July 1, 1985. In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this subchapter until such date as the Secretary determines that such data has been satisfactorily provided.''

Subsec. (v)(1)(S)(ii)(I). Pub. L. 101–508, § 4151(a)(1), inserted before period at end '', by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995''.

Subsec. (v)(1)(S)(ii)(II). Pub. L. 101–508, § 4151(b)(1)(D), added subcl. (II). Former subcl. (II) redesignated (III).

Pub. L. 101–508, § 4151(b)(1)(A), substituted ''Subclauses (I) and (II)'' for ''Subclause (I)'' and ''costs of hospital outpatient services provided by any hospital'' for ''capital-related costs of any hospital''.

Pub. L. 101–508, § 4151(a)(2), substituted ''section 1395ww(d)(5)(D)(iii) of this title or a rural primary care hospital (as defined in subsection (mm)(1))'' for ''section 1395ww(d)(5)(D)(iii) of this title)''.

Subsec. (v)(1)(S)(ii)(III). Pub. L. 101–508, § 4151(b)(1)(C), redesignated former subcl. (II) as (III). Former subcl. (III) redesignated (IV).

Pub. L. 101–508, § 4151(b)(1)(B), substituted ''subclauses (I) and (II)'' for ''subclause (I)'' and ''the costs reflected'' for ''capital-related costs reflected''.

Subsec. (v)(1)(S)(ii)(IV). Pub. L. 101–508, § 4151(b)(1)(C), redesignated subcl. (III) as (IV).

Subsec. (aa). Pub. L. 101–508, § 4161(a)(2)(A), inserted ''and Federally qualified health center services'' after ''clinic services'' in heading.

Subsec. (aa)(1)(B). Pub. L. 101–508, § 4161(a)(5)(B), substituted ''paragraph (5)'' for ''paragraph (3)''.

Subsec. (aa)(2). Pub. L. 101–597 substituted ''health professional shortage area'' for ''health manpower shortage area'' in second sentence.

Pub. L. 101–508, § 4161(b)(1), inserted at end ''If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for certification as such a clinic, the Secretary shall notify the facility of the the Secretary's approval or disapproval of the certification not later than 60 days after the date of the State agency determination or the application (whichever is later).''

Subsec. (aa)(3). Pub. L. 101–508, § 4161(a)(2)(C), added par. (3). Former par. (3) redesignated (5).

Pub. L. 101–508, § 4161(a)(2)(B), which directed amendment of par. (3) by substituting ''the previous provisions of this subsection'' for ''paragraphs (1) and (2)'', could not be executed because the words ''paragraphs (1) and (2)'' did not appear after amendment by Pub. L. 101–508, § 4155(d). See below.

Pub. L. 101–508, § 4155(d), substituted ''The term 'physician assistant', the term 'nurse practitioner', and the term 'clinical nurse specialist' mean, for purposes of this chapter, a physician assistant, nurse practitioner, or clinical nurse specialist who performs'' for ''The term 'physician assistant' and the term 'nurse practitioner' mean, for the purposes of paragraphs (1) and (2), a physician assistant or nurse practitioner who performs''.

Subsec. (aa)(4) to (6). Pub. L. 101–508, § 4161(a)(2)(B), (C), added par. (4) and redesignated former pars. (3) and (4) as (5) and (6), respectively.

Subsec. (aa)(7). Pub. L. 101–508, § 4161(b)(2), added par. (7).

Subsec. (ff)(3). Pub. L. 101–508, § 4162(a), designated existing provision as subpar. (A), substituted ''outpatients or by a community mental health center (as defined in subparagraph (B)),'' for ''outpatients'', and added subpar. (B).

Subsec. (jj). Pub. L. 101–508, § 4163(a)(2), added subsec. (jj) defining ''screening mammography''.

Pub. L. 101–508, § 4156(a)(2), added subsec. (jj) defining ''covered osteoporosis drug''.

1989—Subsec. (a). Pub. L. 101–234, § 101(a), repealed Pub. L. 100–360, § 104(d)(4)(A), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e). Pub. L. 101–239, § 6003(g)(3)(D)(x)(I), inserted at end ''The term 'hospital' does not include, unless the context otherwise requires, a rural primary care hospital (as defined in subsection (mm)(1)).''

Pub. L. 101–234, § 101(a), repealed Pub. L. 100–360, § 104(d)(4)(B), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 104(d)(4)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (m). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 206(a), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (m)(5). Pub. L. 101–239, § 6112(e)(1), amended par. (5) generally. Prior to amendment, par. (5) read as follows: ''medical supplies (other than drugs and biologicals) and durable medical equipment, while under such a plan;''.

Subsec. (s). Pub. L. 101–239, § 6141(a)(1), substituted '', including a laboratory that is part of'' for ''which is independent of a physician's office, a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year,'' in provisions following par. (14).

Subsec. (s)(2)(H)(ii). Pub. L. 101–239, § 6113(b)(2)(A), substituted ''subsection (hh)(2)'' for ''subsection (hh)''.

Subsec. (s)(2)(J). Pub. L. 101–239, § 6114(a)(1), struck out ''and'' at end.

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(a)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (s)(2)(K). Pub. L. 101–239, § 6114(a)(2), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted ''to services described in clause (i) or (ii)'' for ''to such services'' in cl. (iii).

Subsec. (s)(2)(N). Pub. L. 101–239, § 6113(b)(1), added subpar. (N).

Subsec. (s)(12). Pub. L. 101–239, § 6131(a)(2), inserted ''with inserts'' after ''custom molded shoes'' in introductory provisions.

Subsec. (s)(13). Pub. L. 101–234, § 201(a), which repealed Pub. L. 100–360, § 204(a)(1)(B)–(D), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was executed by striking out par. (13) as added by Pub. L. 100–360, § 204(a)(1)(B)–(D), but former par. (13) which was redesignated (14) was not restored in view of intervening redesignation as (15) by Pub. L. 101–239, § 6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(14). Pub. L. 101–239, § 6115(a)(1)(A), (B), (D), added par. (14). Former par. (14) redesignated (15).

Pub. L. 101–234, § 201(a), which repealed Pub. L. 100–360, § 204(a)(1)(A), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening redesignation of par. (14) as (15) by Pub. L. 101–239, § 6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(15). Pub. L. 101–239, § 6115(a)(1)(C), redesignated par. (14) as (15). Former par. (15) redesignated (16).

Pub. L. 101–234, § 201(a), which repealed Pub. L. 100–360, § 204(a)(1)(A), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening redesignation of par. (15) as (16) by Pub. L. 101–239, § 6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(16). Pub. L. 101–239, § 6141(a)(2), (3), added subpar. (A) and designated existing provisions as subpar. (B).

Pub. L. 101–239, § 6115(a)(1)(C), redesignated par. (15) as (16).

Subsec. (t). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(a)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (u). Pub. L. 101–239, § 6003(g)(3)(C)(i), inserted ''rural primary care hospital,'' after ''hospital,''.

Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 203(e)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (v)(1)(G)(i). Pub. L. 101–234, § 101(a), repealed Pub. L. 100–360, § 104(d)(4)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (v)(1)(S). Pub. L. 101–239, § 6110, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (v)(2)(A), (3). Pub. L. 101–234, § 101(a), repealed Pub. L. 100–360, § 104(d)(4)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (w)(1). Pub. L. 101–239, § 6003(g)(3)(D) (x)(II), inserted ''rural primary care hospital,'' after ''hospital,''.

Subsec. (w)(2). Pub. L. 101–239, § 6003(g)(3)(D) (x)(III), substituted ''hospital or rural primary care hospital'' for ''hospital'' in six places.

Subsec. (y). Pub. L. 101–234, § 101(a), repealed Pub. L. 100–360, § 104(d)(4)(E), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (aa)(1)(B). Pub. L. 101–239, § 6213(b), substituted ''(as defined in paragraph (3)), by'' for ''(as defined in paragraph (3)), or by'' and inserted ''or by a clinical social worker (as defined in subsection (hh)(1)),'' after ''Secretary)''.

Subsec. (aa)(2). Pub. L. 101–239, § 6213(c), in second sentence substituted ''designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated by the Secretary'' for ''designated by the Secretary'', ''section 330(b)(3) or 1302(7) of the Public Health Service Act,'' for ''section 1302(7) of the Public Health Service Act or'', and ''medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act,'' for ''medical care manpower,''.

Subsec. (aa)(2)(J), (K). Pub. L. 101–239, § 6213(a), added subpar. (J) and redesignated former subpar. (J) as (K).

Subsec. (aa)(4). Pub. L. 101–239, § 6114(d), added par. (4).

Subsec. (hh). Pub. L. 101–239, § 6113(b)(2)(B), inserted ''; clinical social worker services'' after ''social worker'' in heading, redesignated existing provisions as par. (1), redesignated former pars. (1) to (3) as subpars. (A) to (C), respectively, in subpar. (C), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, in cl. (ii), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added par. (2).

Subsec. (ii). Pub. L. 101–239, § 6113(a), struck out ''on-site at a community mental health center (as such term is used in the Public Health Service Act), and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,'' after ''as defined by the Secretary)''.

Subsecs. (jj) to (*ll*). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, §§ 203(b), 204(a)(2), 205(b), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (mm). Pub. L. 101–239, § 6003(g)(3)(A), added subsec. (mm).

Subsec. (mm)(3). Pub. L. 101–239, § 6116(a)(1), added par. (3).

Subsec. (nn). Pub. L. 101–239, § 6115(a)(2), added subsec. (nn).

1988—Subsec. (a). Pub. L. 100–360, § 104(d)(4)(A), struck out subsec. (a) which defined ''spell of illness''.

Subsec. (a)(2). Pub. L. 100–360, § 411(*l*)(1)(B)(i), (ii), redesignated and amended Pub. L. 100–203, § 4201(d)(1), see 1987 Amendment note below.

Subsec. (e). Pub. L. 100–360, § 104(d)(4)(B), substituted ''and paragraph (7) of this subsection'' for ''paragraph (7) of this subsection, and subsection (i) of this section'' in introductory provisions, struck out second sentence which read as follows: ''For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.'', substituted ''and section 1395f(f)(2) of this title'' for ''section 1395f(f)(2) of this title, and subsection (i) of this section'' in third sentence, and struck out '', except for purposes of subsection (a)(2),'' after ''such term shall not'' in fifth sentence.

Subsec. (i). Pub. L. 100–360, § 104(d)(4)(C), struck out subsec. (i) which defined ''post-hospital extended care services''.

Subsec. (m). Pub. L. 100–360, § 206(a), inserted at end ''For purposes of paragraphs (1) and (4) and sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.''

Subsec. (n). Pub. L. 100–360, § 411(*l*)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), added Pub. L. 100–203, § 4201(d)(5), see 1987 Amendment note below.

Pub. L. 100–360, § 411(*l*)(1)(B)(iii), added Pub. L. 100–203, § 4201(d)(2), see 1987 Amendment note below.

Pub. L. 100–360, § 411(d)(1)(B)(i), inserted ''; except that such term does not include such equipment furnished by a supplier who has used, for the demonstra-

tion and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment'' before period at end.

Subsec. (p). Pub. L. 100–647, § 8424(a), inserted at end ''Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this subchapter, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician.''

Subsec. (s). Pub. L. 100–360, § 411(g)(3)(H), inserted a comma before ''year'' in provisions immediately preceding par. (13).

Subsec. (s)(2)(H)(ii). Pub. L. 100–360, § 411(h)(5)(A), amended Pub. L. 100–203, § 4074(a), see 1987 Amendment note below.

Subsec. (s)(2)(J). Pub. L. 100–360, § 202(a)(1), amended subpar. (J) generally, substituting ''covered outpatient drugs (as defined in subsection (t) of this section); and'' for former provision which related to prescription drugs used in immunosuppressive therapy.

Subsec. (s)(2)(K)(i). Pub. L. 100–360, § 411(h)(6), amended Pub. L. 100–203, § 4076(a), see 1987 Amendment note below.

Subsec. (s)(2)(K)(i)(I). Pub. L. 100–485, § 608(d)(23)(B), substituted ''nursing facility (as defined in section 1396r(a) of this title)'' for ''intermediate care facility (as defined in section 1396d(c) of this title)''.

Subsec. (s)(2)(M). Pub. L. 100–360, § 411(h)(7)(A), made technical amendment to directory language of Pub. L. 100–203, § 4077(b)(1), see 1987 Amendment note below.

Subsec. (s)(10)(A). Pub. L. 100–360, § 411(h)(2), inserted '', subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,'' before ''influenza vaccine''.

Subsec. (s)(12). Pub. L. 100–360, § 411(h)(3)(A), inserted ''subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987,'' in introductory provisions.

Subsec. (s)(13). Pub. L. 100–360, § 204(a)(1)(B)–(D), added par. (13) relating to screening mammography (as defined in subsection (kk) of this section). Former par. (13) redesignated (14).

Subsec. (s)(14). Pub. L. 100–360, § 204(a)(1)(A), redesignated par. (13) as (14). Former par. (14) redesignated (15).

Subsec. (s)(15). Pub. L. 100–360, § 411(i)(4)(C)(iii), amended directory language of Pub. L. 100–203, § 4085(i)(11), to correct an error, see 1987 Amendment note below.

Pub. L. 100–360, § 204(a)(1)(A), redesignated par. (14) as (15).

Subsec. (s)(16). Pub. L. 100–360, § 411(i)(4)(C)(iii), amended directory language of Pub. L. 100–203, § 4085(i)(11), to correct an error, see 1987 Amendment note below.

Subsec. (t). Pub. L. 100–360, § 202(a)(2), designated existing provisions as par. (1), inserted ''and paragraph (2)'', and added pars. (2) to (4) defining ''covered outpatient drug'' and ''covered home IV drug''.

Subsec. (u). Pub. L. 100–360, § 203(e)(1), inserted ''home intravenous drug therapy provider,'' after ''hospice program,''.

Subsec. (v)(1)(G)(i). Pub. L. 100–360, § 104(d)(4)(D), struck out ''post-hospital'' before ''extended care services'' in four places.

Subsec. (v)(1)(L)(iii). Pub. L. 100–360, § 411(d)(5)(A), substituted ''verified'' for ''audited'' in subcls. (I) and (II) and inserted at end ''In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this subchapter until such date as the Secretary determines that such data has been satisfactorily provided.''

Subsec. (v)(2)(A), (3). Pub. L. 100–360, § 104(d)(4)(D), struck out ''post-hospital'' before ''extended care services''.

Subsec. (y). Pub. L. 100–360, § 104(d)(4)(E)(i), substituted ''Extended care'' for ''Post-hospital extended care'' in heading.

Subsec. (y)(1). Pub. L. 100–360, § 104(d)(4)(E)(ii), struck out ''(except for purposes of subsection (a)(2))'' after ''Massachusetts, but only''.

Subsec. (y)(2). Pub. L. 100–360, § 104(d)(4)(E)(i), (iii), (iv), struck out ''post-hospital'' before ''extended care services'' in two places, substituted ''year'' for ''spell of illness'' and ''spell'' wherever each appeared, and substituted ''45 days'' for ''30 days''.

Subsec. (y)(3). Pub. L. 100–360, § 104(d)(4)(E)(i), (iii), (v), struck out ''post-hospital'' before ''extended care services'' and substituted ''year'' for ''spell of illness'', ''the coinsurance amount established under section 1395e(a)(3)(C) of this title for each day before the 46th day'' for ''one-eighth of the inpatient hospital deductible for each day before the 31st day'', and ''year'' for ''spell''.

Subsec. (y)(4). Pub. L. 100–360, § 104(d)(4)(E)(vi), struck out par. (4) which provided that certain determinations about services provided by an institution described in par. (1) be made under regulations.

Subsec. (bb)(2). Pub. L. 100–360, § 411(i)(3), added Pub. L. 100–203, § 4084(c)(1), see 1987 Amendment note below.

Subsec. (ff). Pub. L. 100–360, § 411(h)(1)(B)(i), inserted heading.

Subsec. (ff)(3). Pub. L. 100–360, § 411(h)(1)(B)(ii), substituted ''furnished by a hospital to its outpatients'' for ''hospital-based or hospital-affiliated (as defined by the Secretary)''.

Subsec. (gg). Pub. L. 100–360, § 411(h)(4)(D), amended Pub. L. 100–203, § 4073(c), see 1987 Amendment note below.

Subsec. (hh). Pub. L. 100–360, § 411(h)(5)(B), amended Pub. L. 100–203, § 4074(b), see 1987 Amendment note below.

Subsec. (ii). Pub. L. 100–647, § 8423(a), inserted ''on-site'' before ''at a community mental health center'' and '', and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,'' after ''Public Health Service Act)''.

Pub. L. 100–360, § 411(h)(7)(E), (F), redesignated and amended Pub. L. 100–203, § 4077(b)(4), see 1987 Amendment note below.

Subsec. (jj). Pub. L. 100–485, § 608(d)(6)(A), inserted heading.

Pub. L. 100–360, § 203(b), added subsec. (jj) relating to home intravenous drug therapy services.

Subsec. (kk). Pub. L. 100–360, § 204(a)(2), added subsec. (kk) relating to screening mammography.

Subsec. (*ll*). Pub. L. 100–360, § 205(b), added subsec. (*ll*) relating to in-home care furnished to chronically dependent individual.

1987—Subsec. (a)(2). Pub. L. 100–203, § 4201(d)(1), formerly § 4201(d), as redesignated and amended by Pub. L. 100–360, § 411(*l*)(1)(B)(i), (ii), substituted ''facility described in section 1395i–3(a)(1) of this title or subsection (y)(1)'' for ''skilled nursing facility''.

Subsec. (b)(3). Pub. L. 100–203, § 4009(e)(1), inserted ''(including clinical psychologist (as defined by the Secretary))'' before ''under arrangements''.

Subsec. (b)(4). Pub. L. 100–203, § 4085(i)(9), substituted ''and anesthesia'' for '', anesthesia'' and ''certified registered nurse'' for ''certified certified registered nurse''.

Subsec. (b)(6). Pub. L. 100–203, § 4039(b)(2), substituted ''Council on Podiatric Medical Education of the American Podiatric Medical Association'' for ''Council on Podiatry Education of the American Podiatry Association''.

Subsec. (e)(4). Pub. L. 100–203, § 4009(f), inserted ''with respect to whom payment may be made under this subchapter'' after ''patient''.

Subsec. (g). Pub. L. 100–203, § 4085(i)(10), made technical amendment to heading.

Subsec. (j). Pub. L. 100–203, § 4201(a)(1), amended subsec. generally, substituting provision defining ''skilled nursing facility'' as having the meaning given such term in section 1395i–3(a) of this title for provision defining ''skilled nursing facility'' as, except for purposes of subsec. (a)(2) of this section, an institution or a distinct part of an institution which has in effect a transfer agreement, meeting the requirements of subsec. (*l*) of this section, with one or more hospitals having agreements in effect under section 1395cc of this title and which meet a specified list of criteria.

Subsec. (n). Pub. L. 100–203, § 4201(d)(2), (5), as added by Pub. L. 100–360, § 411(*l*)(1)(B)(iii), and Pub. L. 100–360, § 411(*l*)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), made similar amendments, resulting in the substitution of ''subsection (e)(1) of this section or section 1395i–3(a)(1) of this title'' for ''subsection (e)(1) or (j)(1) of this section'' in introductory provisions.

Subsec. (*o*)(6). Pub. L. 100–203, § 4021(a), inserted ''the conditions of participation specified in section 1395bbb(a) of this title and'' after ''meets''.

Subsec. (r)(3). Pub. L. 100–203, § 4039(b)(1), substituted ''subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title'' for ''subsection (s) of this section'', and struck out ''; and for the purposes of subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only if his performance of functions under subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform''.

Subsec. (s). Pub. L. 100–203, § 4085(i)(11), substituted in closing provisions ''which would not be included under subsection (b) if it were furnished to an inpatient of a hospital.'' for ''which—'' before par. (15) and struck out pars. (15) and (16).

Pub. L. 100–203, § 4064(e)(1), inserted ''a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year'' in provisions preceding par. (13).

Subsec. (s)(2)(B). Pub. L. 100–203, § 4070(b)(1), inserted ''and partial hospitalization services incident to such services'' before semicolon.

Subsec. (s)(2)(H)(ii). Pub. L. 100–203, § 4074(a), as amended by Pub. L. 100–360, § 411(h)(5)(A), inserted ''or by a clinical social worker (as defined in subsection (hh))'' after ''clinical psychologist (as defined by the Secretary)'', and substituted ''incident to such clinical psychologist's services or clinical social worker's services'' for ''incident to his services''.

Subsec. (s)(2)(J). Pub. L. 100–203, § 4075(a), substituted ''prescription drugs used in immunosuppressive therapy'' for ''immunosuppressive drugs''.

Subsec. (s)(2)(K)(i). Pub. L. 100–203, § 4076(a), as amended by Pub. L. 100–360, § 411(h)(6), inserted ''(I)'' and substituted '', (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area,'' for ''or as an assistant at surgery''.

Subsec. (s)(2)(L). Pub. L. 100–203, § 4073(a), added subpar. (L).

Subsec. (s)(2)(M). Pub. L. 100–203, § 4077(b)(1), as amended by Pub. L. 100–360, § 411(h)(7)(A), added subpar. (M).

Subsec. (s)(10)(A). Pub. L. 100–203, § 4071(a), inserted ''and influenza vaccine and its administration'' before semicolon.

Subsec. (s)(12). Pub. L. 100–203, § 4072(a), added par. (12). Former par. (12) redesignated (13).

Subsec. (s)(13), (14). Pub. L. 100–203, § 4072(a)(1), redesignated pars. (12) and (13) as (13) and (14), respectively. Former par. (14) redesignated (15).

Subsec. (s)(15). Pub. L. 100–203, § 4085(i)(11), as amended by Pub. L. 100–360, § 411(i)(4)(C)(iii), struck out par. (15) which read as follows: ''would not be included under subsection (b) of this section if it were furnished to an inpatient of a hospital; or''.

Pub. L. 100–203, § 4072(a)(1), redesignated par. (14) as (15). Former par. (15) redesignated (16).

Subsec. (s)(16). Pub. L. 100–203, § 4085(i)(11), as amended by Pub. L. 100–360, § 411(i)(4)(C)(iii), struck out par. (16) which read as follows: ''is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.''

Pub. L. 100–203, § 4072(a)(1), redesignated par. (15) as (16).

Subsec. (v)(1)(E). Pub. L. 100–203, § 4201(b)(1), inserted at end ''Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1395i–3 of this title (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).''

Subsec. (v)(1)(L)(iii). Pub. L. 100–203, § 4026(a)(1), added cl. (iii).

Subsec. (v)(1)(S). Pub. L. 100–203, § 4065(a), added subpar. (S).

Subsec. (v)(5)(A). Pub. L. 100–203, § 4085(i)(12), made technical amendments to references in original act which appear in text as references to ''subsection (p)'' and ''subsection (g)''.

Subsec. (aa)(1)(B). Pub. L. 100–203, § 4077(a)(1), substituted ''physician assistant or a nurse practitioner (as defined in paragraph (3)), or by a clinical psychologist (as defined by the Secretary),'' for ''physician assistant or by a nurse practitioner''.

Subsec. (bb). Pub. L. 100–203, § 4085(i)(13), made technical amendment to heading.

Subsec. (bb)(2). Pub. L. 100–203, § 4084(c)(1), as added by Pub. L. 100–360, § 411(i)(3), inserted at end ''Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.''

Subsec. (cc)(1). Pub. L. 100–203, § 4078, inserted provision at end relating to location requirements in case of physical therapy, occupational therapy, and speech pathology services.

Subsec. (ee). Pub. L. 100–203, § 4085(i)(14), made technical amendment to heading.

Subsec. (ff). Pub. L. 100–203, § 4070(b)(2), added subsec. (ff).

Subsec. (gg). Pub. L. 100–203, § 4073(c), as amended by Pub. L. 100–360, § 411(h)(4)(D), added subsec. (gg).

Subsec. (hh). Pub. L. 100–203, § 4074(b), as amended by Pub. L. 100–360, § 411(h)(5)(B), added subsec. (hh).

Subsec. (ii). Pub. L. 100–203, § 4077(b)(4), formerly § 4077(b)(5), as redesignated and amended by Pub. L. 100–360, § 411(h)(7)(E), (F), added subsec. (ii).

1986—Subsec. (b)(4). Pub. L. 99–509, § 9320(f), inserted before the semicolon at end '', anesthesia services provided by a certified registered nurse anesthetist''.

Subsec. (e)(6). Pub. L. 99–509, § 9305(c)(1), inserted ''(A)'' after ''(6)'' and cl. (B).

Subsec. (g). Pub. L. 99–509, § 9337(d)(1), added subsec. (g).

Subsec. (n). Pub. L. 99–272, § 9219(b)(1)(B), substituted ''as his home'' for ''at his home''.

Subsec. (r)(4). Pub. L. 99–509, § 9336(a), amended cl. (4) generally. Prior to amendment, cl. (4) read as follows: ''a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to services related to the condition of aphakia, or''.

Subsec. (s)(2)(D). Pub. L. 99–509, § 9337(d)(2), inserted ''and outpatient occupational therapy services''.

Subsec. (s)(2)(J). Pub. L. 99–509, § 9335(c)(1), added subpar. (J).

Subsec. (s)(2)(K). Pub. L. 99–509, § 9338(a), added subpar. (K).

Subsec. (s)(11) to (15). Pub. L. 99–509, § 9320(b), added par. (11) and redesignated former pars. (11) to (14) as (12) to (15), respectively.

Subsec. (v)(1)(B). Pub. L. 99–272, § 9107(b)(2), substituted ''any cost reporting period shall be equal to'' for ''any fiscal period shall not exceed one and one-half times'' and ''the period'' for ''such fiscal period''.

Subsec. (v)(1)(G)(i). Pub. L. 99–272, § 9219(b)(3)(A), inserted ''on the basis of'' after ''(during such period)'' in provisions following subcl. (III).

Subsec. (v)(1)(L). Pub. L. 99–509, § 9315(a), inserted ''(i)'' after ''(L)'', struck out ''the 75th percentile of such costs per visit for free standing home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the mean of the costs of such agencies or otherwise) as the Secretary may determine.'', and substituted in lieu ''for cost reporting periods beginning on or after—

''(I) July 1, 1985, and before July 1, 1986, 120 percent,

''(II) July 1, 1986, and before July 1, 1987, 115 percent, or

''(III) July 1, 1987, 112 percent,

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

''(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.''

Subsec. (v)(1)(O)(i). Pub. L. 99–272, § 9110(a)(1), inserted '', except as provided in clause (iv),'' after ''such regulations shall provide''.

Subsec. (v)(1)(O)(iv). Pub. L. 99–272, § 9110(a)(2), added cl. (iv).

Subsec. (v)(1)(P). Pub. L. 99–272, § 9107(b)(1), added subpar. (P).

Subsec. (v)(1)(Q). Pub. L. 99–272, § 9202(i)(1), added subpar. (Q).

Subsec. (v)(1)(R). Pub. L. 99–509, § 9313(a)(2), added subpar. (R).

Subsec. (v)(5)(A). Pub. L. 99–509, § 9337(d)(3), inserted ''(including through the operation of subsection (g))'' after ''subsection (p)''.

Subsec. (bb). Pub. L. 99–509, § 9320(c), added subsec. (bb).

Subsec. (ee). Pub. L. 99–509, § 9305(c)(2), added subsec. (ee).

1984—Subsec. (d). Pub. L. 98–369, § 2335(b)(1), struck out subsec. (d) which defined ''inpatient tuberculosis hospital services'' as inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Subsec. (e). Pub. L. 98–369, § 2335(b)(2), struck out ''or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g) of this section) or'' before ''unless it is a psychiatric hospital'' in provisions following par. (9).

Subsec. (f). Pub. L. 98–369, § 2340(a), struck out par. (5) which provided that ''psychiatric hospital'' meant an institution which was accredited by the Joint Commission on Accreditation of Hospitals, and struck out ''if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary'' in concluding provisions.

Subsec. (g). Pub. L. 98–369, § 2335(b)(1), struck out subsec. (g) which defined ''tuberculosis hospital''.

Subsec. (j). Pub. L. 98–369, § 2335(b)(3), in provisions following par. (15), struck out ''or tuberculosis'' after ''treatment of mental diseases''.

Subsec. (j)(2). Pub. L. 98–369, § 2354(b)(18), substituted ''provision for'' for ''provision of''.

Subsec. (j)(13). Pub. L. 98–369, § 2354(b)(19), substituted ''an institution'' for ''a nursing home''.

Subsec. (m)(5). Pub. L. 98–369, § 2321(e)(1), which directed the substitution of ''and durable medical equipment'' for '', and the use of medical applicances'' was executed by making the substitution for '', and the use of medical appliances'' as the probable intent of Congress.

Subsec. (n). Pub. L. 98–369, § 2321(e)(3), added subsec. (n).

Subsec. (p)(1). Pub. L. 98–369, § 2341(a), substituted ''paragraph (1) or (3) of subsection (r)'' for ''subsection (r)(1)''.

Subsec. (p)(2). Pub. L. 98–369, § 2342(a), substituted ''by a physician as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined)'' for '', and is periodically reviewed, by a physician (as so defined)''.

Subsec. (r)(3). Pub. L. 98–617, § 3(b)(7), substituted ''under subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title'' for ''under subsections (k) and (m) and sections 1395f(a) and 1395n of this title'' before ''is consistent with the policy''.

Pub. L. 98–369, § 2341(c), substituted ''for the purposes of subsections (k), (m), and (p)(1) of this section'' for ''for the purposes of subsections (k) and (m) of this section'', and substituted ''sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only if'' for ''sections 1395f(a) and 1395n of this title but only if''.

Subsec. (s)(2)(H). Pub. L. 98–369, § 2322(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (s)(2)(I). Pub. L. 98–369, § 2324(a), added subpar. (I).

Subsec. (s)(6). Pub. L. 98–369, § 2321(e)(2), struck out provision which included iron lungs, oxygen tents, etc. with durable medical equipment. See subsec. (n) of this section.

Subsec. (s)(10). Pub. L. 98–369, § 2323(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (u). Pub. L. 98–369, § 2354(b)(20), struck out ''or'' before ''home health agency''.

Subsec. (v)(1)(B). Pub. L. 98–369, § 2354(b)(21)(A), realigned margin of subpar. (B).

Subsec. (v)(1)(C). Pub. L. 98–369, § 2354(b)(21)(B), realigned margins of subpar. (C).

Subsec. (v)(1)(C)(i). Pub. L. 98–369, § 2354(b)(22), inserted a dash after ''but only if''.

Subsec. (v)(1)(D). Pub. L. 98–369, § 2354(b)(21)(B), realigned margin of subpar. (D).

Pub. L. 98–369, § 2354(b)(21)(C), inserted a comma after ''section 1395k(a)(2)(B)(i) of this title''.

Subsec. (v)(1)(E). Pub. L. 98–369, § 2319(a)(1), struck out cl. (i) which directed that such regulations provide that any determination of reasonable cost with respect to services provided by hospital-based skilled nursing facilities be made on the basis of a single standard based on the reasonableness of costs incurred by free standing skilled nursing facilities, subject to such adjustments as deemed appropriate by the Secretary, and struck out the designation ''(ii)''.

Pub. L. 98–369, § 2354(b)(23), as amended by Pub. L. 98–617, § 3(a)(4), substituted ''use'' for ''uses''.

Subsec. (v)(1)(I)(i), (ii). Pub. L. 98–369, § 2354(b)(24), substituted ''by the Secretary, or upon request by the Comptroller General'' for ''to the Secretary, or upon request to the Comptroller General''.

Subsec. (v)(1)(K). Pub. L. 98–369, § 2318(a), (b), designated existing provisions as cl. (i), substituted therein ''as defined in clause (ii)'' for ''provided in an emergency room'', and added cl. (ii).

Subsec. (v)(1)(O). Pub. L. 98–369, § 2314(a), added subpar. (O).

Subsec. (v)(3). Pub. L. 98–369, § 2354(b)(25), substituted ''semi-private'' for ''semiprivate'' after ''furnished in''.

Subsec. (v)(7)(D). Pub. L. 98–369, § 2319(a)(2), added subpar. (D).

Subsec. (z)(2). Pub. L. 98–369, § 2354(b)(26), substituted ''paragraph (1)'' for ''subparagraph (1)''.

Subsec. (aa)(2)(I). Pub. L. 98–369, § 2354(b)(27), substituted ''utilization'' for ''ultilization''.

Subsec. (cc)(1)(F). Pub. L. 98–369, § 2354(b)(28), substituted ''self-administered'' for ''self administered''.

Subsec. (cc)(1)(G). Pub. L. 98–369, § 2321(e)(4), substituted ''and durable medical equipment'' for '', appliances, and equipment, including the purchase or rental of equipment''.

Subsec. (cc)(2)(F). Pub. L. 98–369, § 2354(b)(29), substituted ''standards established'' for ''standard establishment''.

Subsec. (dd)(2)(A)(ii)(I). Pub. L. 98–369, §2343(a), inserted ''except as otherwise provided in paragraph (5),''.

Subsec. (dd)(5). Pub. L. 98–369, §2343(b), added par. (5).

1983—Subsec. (v)(1)(G)(i). Pub. L. 98–21, §602(d)(1), substituted ''the amount otherwise payable under part A with respect to'' for ''on the basis of the reasonable cost of'' in provisions following subcl. (III).

Subsec. (v)(2)(A). Pub. L. 98–21, §602(d)(2), substituted ''the amount that would be taken into account with respect to'' for ''an amount equal to the reasonable cost of''.

Subsec. (v)(2)(B). Pub. L. 98–21, §602(d)(3), struck out ''the equivalent of the reasonable cost of'' after ''only''.

Subsec. (v)(3). Pub. L. 98–21, §602(d)(4), substituted ''the amount otherwise payable under this subchapter for such bed and board furnished in semiprivate accommodations'' for ''the reasonable cost of such bed and board furnished in semiprivate accommodations (determined pursuant to paragraph (1))''.

Subsec. (v)(7)(C). Pub. L. 97–448 amended directory language of Pub. L. 97–248, §109(b)(2), to correct typographical error, and did not involve any change in text. See 1982 Amendment note below.

Subsec. (z)(2). Pub. L. 98–21, §607(d), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 98–21, §607(b)(2), substituted ''$600,000 (or such lesser amount as may be established by the State under section 1320a–1(g)(1) of this title in which the hospital is located)'' for ''$100,000''.

1982—Subsec. (e)(C). Pub. L. 97–248, §128(d)(2), substituted ''(i) may'' for ''may (i),''.

Subsec. (s)(2)(H). Pub. L. 97–248, §114(b), added subpar. (H).

Subsec. (u). Pub. L. 97–248, §122(d)(1), inserted ''hospice program,'' after ''home health agency,''.

Subsec. (v)(1)(E). Pub. L. 97–248, §102(a), struck out provisions that this subparagraph would not apply to any skilled nursing facility that either was a distinct part of or directly operated by a hospital or was in a close, formal satellite relationship with a participating hospital, and in the case of the latter, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection would not exceed 150 percent of the costs determined by the application of this subparagraph, redesignated the remainder as cl. (ii), and added cl. (i).

Subsec. (v)(1)(G)(i). Pub. L. 97–248, §148(b), substituted ''quality control and peer review organization'' for ''Professional Standards Review Organization''.

Subsec. (v)(1)(H)(iii). Pub. L. 97–248, §109(b)(1), struck out ''(I)'' and '', or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency''.

Subsec. (v)(1)(I). Pub. L. 97–248, §127(1), amended directory language of Pub. L. 96–499, §952, by inserting ''(a)'' after ''952'', and did not involve any change in text. See 1980 Amendment note below.

Subsec. (v)(1)(J). Pub. L. 97–248, §103(a), substituted provisions that cost regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities for provisions that such regulations would provide that an inpatient routine nursing salary cost differential would be allowable as a reimbursable cost of hospitals, at a rate not to exceed 5 percent, to be applied under the same methodology used for the nursing salary cost differential for the month of April 1981.

Subsec. (v)(1)(L). Pub. L. 97–248, §101(a)(2), struck out cl. (i) which provided that the Secretary, in determining the amount of the payments that could be made under this subchapter with respect to routine operating costs for the provision of general inpatient hospital services, could not recognize as reasonable, routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceeded 108 percent of the mean of such routine operating costs per diem for hospitals, or, in the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary could determine, and struck out ''(ii)''.

Pub. L. 97–248, §105(a), inserted ''free standing'' after ''costs per visit for''.

Subsec. (v)(1)(M). Pub. L. 97–248, §106(a), added subpar. (M).

Subsec. (v)(1)(N). Pub. L. 97–248, §107(a), added subpar. (N).

Subsec. (v)(7). Pub. L. 97–248, §101(d), redesignated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (v)(7)(C). Pub. L. 97–248, §108(a)(2), added subpar. (C).

Pub. L. 97–248, §109(b)(2), as amended by Pub. L. 97–448, §309(a)(4), inserted ''and for payments under certain percentage arrangements''.

Subsec. (w)(1). Pub. L. 97–248, §122(d)(2), substituted ''home health agency, or hospice program'' for ''or home health agency''.

Subsec. (w)(2). Pub. L. 97–248, §148(b), substituted ''quality control and peer review organization'' for ''Professional Standards Review Organization''.

Subsec. (cc)(1). Pub. L. 97–248, §128(a)(1), substituted ''inpatient'' for ''outpatient'' in provisions following subpar. (H).

Subsec. (dd). Pub. L. 97–248, §122(d)(3), added subsec. (dd).

1981—Subsec. (u). Pub. L. 97–35, §2121(c), struck out ''detoxification facility,'' after ''home health agency,''.

Subsec. (v)(1)(G)(i). Pub. L. 97–35, §2102(a)(1), substituted ''there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital'' for ''the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more'' in provision following subcl. (III).

Pub. L. 97–35, §2114, substituted ''the Secretary or such agent as the Secretary may designate'' for ''an organization or agency with review responsibility as is otherwise provided for under part A of subchapter XI of this chapter'' in provision preceding subcl. (I).

Subsec. (v)(1)(G)(iv). Pub. L. 97–35, §2102(a)(2), substituted provisions that the determination under cl. (i) of this subparagraph, in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, be made on the basis of only the public hospitals which are in the area of the hospital and which are under common ownership with that hospital for provisions that public hospitals under common ownership may elect to be treated as a single hospital, and beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment was made to the hospital only because of this subparagraph or section 1396a(h) of this title for such determination.

Subsec. (v)(1)(J). Pub. L. 97–35, §2141(a), added subpar. (J).

Subsec. (v)(1)(K). Pub. L. 97–35, §2142(a), added subpar. (K).

Subsec. (v)(1)(L). Pub. L. 97–35, §2143(a), added subpar. (L).

Pub. L. 97–35, §2144(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (w)(2). Pub. L. 97–35, §2193(c)(9), substituted ''subchapter XIX'' for ''subchapter V or XIX''.

Subsec. (bb). Pub. L. 97–35, §2121(d), struck out subsec. (bb) which defined ''alcohol detoxification facility services'' and ''detoxification facility''.

1980—Subsec. (b)(7). Pub. L. 96–499, §948(a)(1), provided that par. (4) was not to apply to services provided in a hospital by a physician where the hospital had a teaching program approved as specified in par. (6) if the hospital elected to receive payment for reasonable costs of such services and all physicians in such hospital agreed not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

Subsec. (e). Pub. L. 96–499, §930(k), substituted ''subsection (i)'' for ''subsections (i) and (n)'' in text preceding par. (1) and in text following par. (9).

Pub. L. 96–499, §949, in text following par. (9), inserted provision defining ''hospital'' as a facility of fifty beds

or less located in an area determined by the Secretary to meet definition relating to a rural area described in subpar. (A) of par. (5) and prescribing exceptions to such definition.

Subsec. (i). Pub. L. 96–499, § 950, substituted ''30 days'' for ''14 days'' in three places and struck out former cl. (B) which related to admission to skilled nursing facilities within 28 days after hospital discharge of an individual unable to be admitted to such facilities within 14 days because of a shortage of appropriate bed space, and redesignated former cl. (C) as (B).

Subsec. (j)(13). Pub. L. 96–499, § 915(a), substituted ''such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association'' for ''the Life Safety Code of the National Fire Protection Association (23rd edition, 1973)''.

Subsec. (k)(2)(A). Pub. L. 96–499, § 951(b), inserted ''(of which at least two must be physicians described in subsection (r)(1) of this section)'' after ''two or more physicians''.

Subsec. (m)(4). Pub. L. 96–499, § 930(*l*), inserted ''who has successfully completed a training program approved by the Secretary'' after ''health aide''.

Subsec. (n). Pub. L. 96–499, § 930(m), struck out subsec. (n) which defined ''post-hospital home health services''.

Subsec. (*o*). Pub. L. 96–499, § 930(n)(2), in provisions following par. (7), struck out provision that ''home health agency'' was not to include a private organization which was not a nonprofit organization exempt from Federal income taxation under section 501 of title 26 unless it were licensed pursuant to State law and met such additional standards and requirements as prescribed by regulations.

Subsec. (*o*)(7). Pub. L. 96–499, § 930(n)(1), added par. (7).

Subsec. (r)(2). Pub. L. 96–499, § 936(a), amended cl. (2) generally to expand definition of ''physician'' to include doctors of dental surgery or dental medicine acting within the scope of their licenses.

Subsec. (r)(3). Pub. L. 96–499, § 951(a), substituted provisions relating to doctors of podiatric medicine for provisions relating to doctors of podiatry and surgical chiropody.

Subsec. (r)(4). Pub. L. 96–499, § 937(a), substituted ''services related to the condition of aphakia'' for ''establishing the necessity for prosthetic lenses''.

Subsec. (s)(2)(G). Pub. L. 96–499, § 938(a), added subpar. (G).

Subsec. (s)(10) to (14). Pub. L. 96–611, § 1(a)(1), added par. (10) and redesignated former pars. (10) to (13) as (11) to (14), respectively.

Subsec. (u). Pub. L. 96–499, § 933(c), inserted ''comprehensive outpatient rehabilitation facility,'' after ''nursing facility''.

Pub. L. 96–499, § 931(c), inserted ''detoxification facility,''.

Subsec. (v)(1)(G). Pub. L. 96–499, § 902(a)(1), added subpar. (G).

Subsec. (v)(1)(H). Pub. L. 96–499, § 930(p), added subpar. (H).

Subsec. (v)(1)(I). Pub. L. 96–499, § 952(a), formerly § 952, as redesignated by Pub. L. 97–248, § 127(1), added subpar. (I).

Subsec. (z). Pub. L. 96–499, § 933(d), which purported to substitute ''skilled nursing facility, comprehensive outpatient rehabilitation facility,'' for ''extended care facility,'' was executed by inserting ''comprehensive outpatient rehabilitation facility,'' after ''skilled nursing facility,'' as the probable intent of Congress, in view of the substitution of ''skilled nursing facility'' for ''extended care facility'' by section 278(b)(6) of Pub. L. 92–603.

Subsec. (aa)(1)(A). Pub. L. 96–611, § 1(b)(3), inserted reference to items and services described in subsection (s)(10) of this section.

Subsec. (bb). Pub. L. 96–499, § 931(d), added subsec. (bb).

Subsec. (cc). Pub. L. 96–499, § 933(e), added subsec. (cc).

1978—Subsec. (s)(2)(F). Pub. L. 95–292 added subpar. (F).

1977—Subsec. (j)(11). Pub. L. 95–142, § 3(a)(2), substituted provisions relating to compliance with requirements of section 1320a–3 of this title, for provisions relating disclosure of ownership, corporate status, etc., information to the Secretary or his delegate.

Subsec. (j)(13). Pub. L. 95–142, § 21(a), struck out ''; and'' after ''nursing facilities''.

Subsec. (j)(14). Pub. L. 95–142, § 21(a), added par. (14).

Subsec. (s). Pub. L. 95–210, § 1(g), (h), added subpar. (E) of par. (2) and in provisions following par. (9) inserted '', a rural health clinic,'' after ''independent of a physician's office''.

Subsec. (s)(6). Pub. L. 95–216 inserted ''(which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe)'' after ''wheelchairs''.

Subsec. (v)(1)(F). Pub. L. 95–142, § 19(b)(1), added subpar. (F).

Subsec. (w)(2). Pub. L. 95–142, § 5(m), inserted ''part B of this subchapter or under'' after ''or entitled to have payment made for such services under''.

Subsec. (aa). Pub. L. 95–210, § 1(d), added subsec. (aa).

1975—Subsec. (e)(5). Pub. L. 94–182, § 102, substituted ''January 1, 1979'' for ''January 1, 1976''.

Subsec. (j)(13). Pub. L. 94–182, § 106(a), substituted ''23d edition, 1973'' for ''21st edition, 1967''.

Subsec. (w). Pub. L. 94–182, § 112(a)(1), designated existing provisions as par. (1) and added par. (2).

1972—Subsec. (a)(2). Pub. L. 92–603, § 278(a)(4), substituted ''skilled nursing facility'' for ''extended care facility'' and ''a'' for ''an''.

Subsec. (b)(6). Pub. L. 92–603, §§ 227(a), 276(a), redesignated existing second sentence of subsec. (b) as par. (6) and in subsec. (b)(6) as so designated inserted reference to services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association.

Subsec. (b)(7). Pub. L. 92–603, § 227(a), added par. (7).

Subsec. (e). Pub. L. 92–603, § 211(b), inserted reference to section 1395f(f) of this title in the provisions preceding par. (1), inserted reference to sections 1395f(f)(2) of this title after ''For purposes of sections 1395f(d) and 1395n(b) of this title (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections),'', and inserted provisions for accreditation by the Joint Commission on Accreditation of Hospitals.

Subsec. (e)(8). Pub. L. 92–603, § 234(a), added par. (8). Former par. (8) redesignated (9).

Subsec. (e)(9). Pub. L. 92–603, §§ 234(a), 244(c), redesignated former par. (8) as (9) and struck out provisions requiring that other requirements not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals.

Subsecs. (f)(2), (g)(2). Pub. L. 92–603, § 234(b), (c), inserted reference to par. (9) of subsec. (e) of this section.

Subsec. (h). Pub. L. 92–603, § 278(a)(5), substituted ''skilled nursing facility'' for ''extended care facility'', ''skilled nursing facilities'' for ''extended care facilities'' and ''a'' for ''an''.

Subsec. (i). Pub. L. 92–603, §§ 248, 278(a)(6), (b)(10), extended the class of persons qualifying to be deemed as having been an inpatient in a hospital immediately before transfer therefrom by designating as clause (A) the existing requirement that the person have been admitted to the skilled nursing facility within 14 days after discharge from such hospital and adding cls. (B) and (C) and substituted ''skilled nursing facility'' for ''extended care facility''.

Subsec. (j). Pub. L. 92–603, § 278(a)(7), substituted ''skilled nursing facility'' for ''extended care facility'' in provisions preceding par. (1).

Subsec. (j)(10). Pub. L. 92–603, § 234(d), added par. (10). Former par. (10) redesignated par. (11) by section 234(d)(2) of Pub. L. 92–603 and again redesignated par. (15) by section 246(b)(2) of Pub. L. 92–603.

Subsec. (j)(11) to (13). Pub. L. 92–603, § 246(b)(3), added pars. (11) to (13).

Subsec. (j)(15). Pub. L. 92–603, §§ 234(d), 246(b)(2), (4), 265, 267, 278(b)(13), redesignated former par. (10) as (11), amended par. (11) as thus redesignated by inserting provisions that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution, redesignated such par. (11) as thus amended as par. (15), and inserted provision that all information concerning skilled nursing facilities required to be filed with the Secretary be made available to Federal and state employees for purposes consistent with the effective administration of programs established under subchapters XVIII and XIX and inserted provision for the waiver of the registered nurse requirement in skilled nursing facilities in rural areas.

Subsec. (k). Pub. L. 92–603, §§ 237(c), 278(a)(8), inserted provisions authorizing the Secretary to utilize the procedures established under subchapter XIX of this chapter if such procedures were determined to be superior in their effectiveness and substituted ''skilled nursing facility'' for ''extended care facility'', ''skilled nursing facilities'' for ''extended care facilities'', and ''a'' for ''an''.

Subsec. (*l*). Pub. L. 92–603, § 278(a)(9), substituted ''skilled nursing facility'' for ''extended care facility'' and ''a'' for ''an''.

Subsec. (m)(7). Pub. L. 92–603, § 278(a)(10), substituted ''skilled nursing facility'' for ''extended care facility''.

Subsec. (n). Pub. L. 92–603, § 278(a)(11), substituted ''skilled nursing facility'' for ''extended care facility'' and ''a'' for ''an''.

Subsec. (*o*)(5), (6). Pub. L. 92–603, § 234(e), added par. (5) and redesignated former par. (5) as (6).

Subsec. (p). Pub. L. 92–603, §§ 251(a)(1), (b)(1), 283(a), inserted provisions covering physical therapy services of a licensed physical therapist other than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, inserted ''In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility'', and extended definition of ''outpatient physical therapy services'' to include outpatient speech pathology services.

Subsec. (q). Pub. L. 92–603, § 227(f), substituted ''subsection (b)(6)'' for ''the last sentence of subsection (b)'' in parenthetical phrase.

Subsec. (r). Pub. L. 92–603, §§ 211(c)(2), 256(b), 264(a), 273(a), inserted ''or (C) the certification required by section 1395x(a)(2)(E) of this title,'' inserted provision so as to include doctors in one of the specified arts legally authorized to practice such art in the country in which inpatient hospital services referred to in section 1395y(a)(4) are furnished, added cl. (4) covering doctors of optometry who are legally authorized to practice optometry by the State in which they perform such functions, but only with respect to establishing the necessity for prosthetic lenses, and added cl. (5) providing for the inclusion of chiropractor services.

Subsec. (s)(8). Pub. L. 92–603, § 252(a), inserted ''(including colostomy bags and supplies directly related to colostomy care)'' after ''organ''.

Subsec. (u). Pub. L. 92–603, §§ 227(d)(1), 278(a)(12), substituted ''skilled nursing facility, or home health agency, or, for purposes of sections 1395(g) and 1395n(e) of this title, a fund.'' for ''extended care facility, or home health agency.''.

Subsec. (v)(1). Pub. L. 92–603, §§ 223(a), (b), (c), (d), 227(c)(1), (2), (3), (4), 249(b), 278(b)(11), inserted definition of the costs of services, inserted provision that the regulation for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonably based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, inserted parenthetical provisions covering exclusion of costs, substituted ''the necessary costs of efficiently delivering covered services covered by the insurance programs'' for ''the costs with respect to individuals covered by the insurance programs'', designated existing provisions as subpars. (A) and (B), and added subpars. (C), (D), and (E), and substituted ''skilled nursing facilities'' for ''extended care facilities''.

Subsec. (v)(3). Pub. L. 92–603, § 278(a)(13), substituted ''skilled nursing facility'' for ''extended care facility''.

Subsec. (v)(4). Pub. L. 92–603, § 223(f), added par. (4). Former par. (4) redesignated (6).

Subsec. (v)(5). Pub. L. 92–603, § 251(c), added par. (5).

Subsec. (v)(6). Pub. L. 92–603, §§ 223(f), 251(c), redesignated former par. (4) as (6).

Subsec. (v)(7). Pub. L. 92–603, §§ 221(c)(4), 223(b), 251(c), added par. (7).

Subsecs. (w), (y). Pub. L. 92–603, § 278(a)(14), (15), substituted ''skilled nursing facility'' for ''extended care facility'' and ''a'' for ''an''.

Subsec. (z). Pub. L. 92–603, §§ 234(b), 278(b)(6), added subsec. (z) and substituted ''skilled nursing facility'' for ''extended care facility''.

1971—Subsec. (e)(5). Pub. L. 91–690 authorized the Secretary, until January 1, 1976, to waive the requirement relating to the provision of 24 hour nursing service rendered or supervised by a registered professional nurse.

1968—Subsec. (e). Pub. L. 90–248, § 129(c)(9)(C), inserted reference to section 1395n(b) in first and third sentences and inserted ''or diagnostic services'' after ''hospital services'' in third sentence.

Pub. L. 90–248, § 143(a), in second sentence after par. (8), changed definition of hospitals for purposes of making payments for emergency hospital services by deleting provision that hospital meet requirements of pars. (1) to (4), by requiring that such hospitals have full-time nursing services, be licensed as a hospital, and be primarily engaged in providing not nursing care and related services but medical or rehabilitative care by or under the supervision of a doctor of medicine or osteopathy.

Subsec. (p). Pub. L. 90–248, §§ 129(c)(10), 133(b), struck out definition of ''outpatient hospital diagnostic services'' and inserted definition of ''outpatient physical therapy services'', respectively.

Subsec. (r)(3). Pub. L. 90–248, § 127(a), added cl. (3).

Subsec. (s). Pub. L. 90–248, § 144(a)–(c), struck out ''(unless they would otherwise constitute inpatient hospital services, extended care services, or home health services)'' after ''items or services'' in text preceding par. (1), inserted after ''hospital'' in sentence following par. (9) ''which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title)'', and inserted sentence following par. (13) providing that medical and other health services (other than physicians' services and services incident to physicians' services) furnished a patient of a facility which meets the definition of a hospital for emergency services will be covered under the medical insurance program only if such facility satisfies such health and safety requirements as are appropriate for the item or service furnished as the Secretary may determine are necessary.

Subsec. (s)(2)(A) to (C). Pub. L. 90–248, § 129(a), designated existing provisions as subpars. (A) and (B) and added subpar. (C).

Subsec. (s)(2)(D). Pub. L. 90–248, § 133(a), added subpar. (D).

Subsec. (s)(3). Pub. L. 90–248, § 134(a), included in medical and other health services diagnostic X-ray tests furnished in the patient's home under the supervision of a physician if the tests meet such health and safety conditions as the Secretary finds necessary.

Subsec. (s)(6). Pub. L. 90–248, § 132(a), provided that payments may be made with respect to expenses incurred in the purchase as well as in the rental of durable medical equipment.

Pub. L. 90–248, § 144(d), inserted ''other than in institution that meets the requirements of subsection (e)(1) or (j)(1) of this section''.

Subsec. (s)(12), (13). Pub. L. 90–248, §129(b), added pars. (12) and (13) which excluded from the diagnostic services referred to in par. (2)(C) (other than physician's services) certain items or service.

Subsec. (y)(3). Pub. L. 90–248, §129(c)(11), substituted ''1395e(a)(3)'' for ''1395e(a)(4)''.

1966—Subsec. (v)(1). Pub. L. 89–713 inserted provisions which required that, in the case of extended care services furnished by proprietary facilities, the regulations include provision for specific recognition of a reasonable return on equity capital and which placed a limitation on the rate of return of one and one-half times the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

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

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §117(b), Dec. 27, 2020, 134 Stat. 2950, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 2021.''

Amendment by section 125(a)(1), (d)(1) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by section 3708 of Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395*f* of this title.

Amendment by section 3713(a) of Pub. L. 116–136 effective on Mar. 27, 2020, and applicable with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 262 of this title, see section 3713(d) of Pub. L. 116–136, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2002(d), Oct. 24, 2018, 132 Stat. 3926, provided that: ''The amendments made by this section [amending this section] shall apply to examinations and visits furnished on or after January 1, 2020.''

Amendment by section 51006(a)(1) of Pub. L. 115–123 applicable to items and services furnished on or after Jan. 1, 2019, see section 51006(b) of Pub. L. 115–123, set out as a note under section 1395f of this title.

Pub. L. 115–123, div. E, title X, §51008(c), Feb. 9, 2018, 132 Stat. 297, provided that: ''The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 2024.''

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2021, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable to items furnished on or after Jan. 1, 2017, see section 504(d) of Pub. L. 114–113, set out as a note under section 1395*l* of this title.

Pub. L. 114–40, §2(b), July 30, 2015, 129 Stat. 441, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to devices furnished on or after January 1, 2016.''

EFFECTIVE DATE OF 2011 AMENDMENT

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

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1301(c), Mar. 30, 2010, 124 Stat. 1057, provided that: ''The amendments made by this section [amending this section] shall apply to items and services furnished on or after the first day of the first calendar quarter that begins at least 12 months after the date of the enactment of this Act [Mar. 30, 2010].''

Amendment by section 4103(a), (b) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395*l* of this title.

Amendment by section 4104(a) of Pub. L. 111–148 applicable to items and services furnished on or after Jan. 1, 2011, see section 4104(d) of Pub. L. 111–148, set out as a note under section 1395*l* of this title.

Pub. L. 111–148, title V, §5502(a)(2), Mar. 23, 2010, 124 Stat. 654, which provided that the amendment made by section 5502(a)(1) (amending this section) applied to services furnished on or after Jan. 1, 2011, was repealed by Pub. L. 111–148, title X, §10501(i)(1), Mar. 23, 2010, 124 Stat. 997.

Pub. L. 111–148, title X, §10501(i)(2)(B), Mar. 23, 2010, 124 Stat. 997, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to services furnished on or after January 1, 2011.''

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–355, §7(b), Oct. 8, 2008, 122 Stat. 3995, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 8, 2008].''

Amendment by section 101(a)(1), (b)(1) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 101(c) of Pub. L. 110–275, set out as a note under section 1395*l* of this title.

Amendment by section 125(b)(2) of Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Amendment by section 143(a), (b)(5), (6) of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Amendment by section 144(a)(1) of Pub. L. 110–275 applicable to items and services furnished on or after Jan. 1, 2010, see section 144(a)(3) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

Amendment by section 152(b)(1)(A), (B) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2010, see section 152(b)(2) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5112(a), (b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395*l* of this title.

Amendment by section 5114(a)(1), (b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2006, see section 5114(c) of Pub. L. 109–171, set out as a note under section 1395u of this title.

Amendment by section 6001(f)(1) of Pub. L. 109–171 effective Feb. 8, 2006, see section 6001(f)(3) of Pub. L. 109–171, set out as a note under section 1396r–8 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 415(b) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, see

section 415(c) of Pub. L. 108–173, set out as a note under section 1395m of this title.

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

Amendment by section 611(a), (b), (d)(2) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, but only for individuals whose coverage period under this part begins on or after such date, see section 611(e) of Pub. L. 108–173, set out as a note under section 1395w–4 of this title.

Pub. L. 108–173, title VI, §612(d), Dec. 8, 2003, 117 Stat. 2305, provided that: ''The amendments made by this section [amending this section and section 1395y of this title] shall apply to tests furnished on or after January 1, 2005.''

Pub. L. 108–173, title VI, §613(d), Dec. 8, 2003, 117 Stat. 2306, provided that: ''The amendments made by this section [amending this section and section 1395y of this title] shall apply to tests furnished on or after January 1, 2005.''

Amendment by section 642(a) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2004, see section 642(c) of Pub. L. 108–173, set out as a note under section 1395*l* of this title.

Pub. L. 108–173, title IX, §926(b)(2), Dec. 8, 2003, 117 Stat. 2396, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to discharge plans made on or after such date as the Secretary [of Health and Human Services] shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a) [enacting provisions set out as a note under this section].''

Amendment by section 946(a) of Pub. L. 108–173 applicable to hospice care provided on or after Dec. 8, 2003, see section 946(c) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §101(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after July 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title I, §102(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, provided that: ''The amendments made by this section [amending this section and section 1395y of this title] shall apply to services furnished on or after January 1, 2002.''

Amendment by section 1(a)(6) [title I, §103(a)] of Pub. L. 106–554 applicable to colorectal cancer screening services provided on or after July 1, 2001, see section 1(a)(6) [title I, §103(c)] of Pub. L. 106–554, set out as a note under section 1395m of this title.

Amendment by section 1(a)(6) [title I, §105(a), (b)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §105(e)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title I, §112(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs and biologicals administered on or after the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 106–554, §1(a)(6) [title I, §113(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs furnished on or after the date of the enactment of this Act [Dec. 21, 2000].''

Amendment by section 1(a)(6) [title IV, §430(b)] of Pub. L. 106–554 applicable to items and services furnished on or after July 1, 2001, see section 1(a)(6) [title IV, §430(c)] of Pub. L. 106–554, set out as a note under section 1395*l* of this title.

Pub. L. 106–554, §1(a)(6) [title IV, §431(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to community mental health centers with respect to services furnished on or after the first day of the third month beginning after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title II, §201(k)] of Pub. L. 106–113 effective as if included in enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see §1000(a)(6) [title II, §201(m)] of Pub. L. 106–113, set out as a note under section 1395*l* of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, provided that: ''The amendments made by paragraph (1) [amending this section] apply to services furnished on or after January 1, 2000.''

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §303(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361, provided that: ''The amendments made by this section [amending this section and section 1395fff of this title] shall apply to services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1999.''

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §304(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361, provided that: ''The amendments made by this section [enacting section 1320a–7f of this title and amending this section] take effect on the date of the enactment of this Act [Nov. 29, 1999], and in applying section 1861(*o*)(7) of the Social Security Act (42 U.S.C. 1395x(*o*)(7)), as amended by subsection (a), the Secretary of Health and Human Services may take into account the previous period for which a home health agency had a surety bond in effect under such section before such date.''

Amendment by section 1000(a)(6) [title III, §321(k)(7)–(9)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4102(a), (c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4103(a) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4104(a)(1) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4105(a)(1), (b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, §4106(d), Aug. 5, 1997, 111 Stat. 368, provided that: ''The amendments made by this section [amending this section and sections 1395w–4, 1395aa, 1396a, and 1396n of this title] shall apply to bone mass measurements performed on or after July 1, 1998.''

Amendment by section 4201(c)(1), (2) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4205(b)(2), Aug. 5, 1997, 111 Stat. 376, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1998.''

Pub. L. 105–33, title IV, §4205(c)(2), Aug. 5, 1997, 111 Stat. 376, provided that: ''The amendment made by paragraph (1) [amending this section] applies to waiver requests made on or after January 1, 1998.''

Pub. L. 105–33, title IV, §4205(d)(4), Aug. 5, 1997, 111 Stat. 377, provided that:

''(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs

[amending this section and section 1395u of this title] take effect on the date of the enactment of this Act [Aug. 5, 1997].

''(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on the date of the enactment of this Act [sic].

''(C) GRANDFATHERED CLINICS.—

''(i) IN GENERAL.—The amendment made by paragraph (3)(A) [amending this section] shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

''(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3)(A) that shall take effect no later than January 1, 1999.''

Amendment by section 4312(d), (e) of Pub. L. 105–33 effective Aug. 5, 1997, and may be applied with respect to items and services furnished on or after Jan. 1, 1998, see section 4312(f)(3) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, § 4312(f)(2), Aug. 5, 1997, 111 Stat. 388, provided that: ''The amendments made by subsection (b) [amending this section] shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.''

Pub. L. 105–33, title IV, § 4321(d)(1), Aug. 5, 1997, 111 Stat. 395, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to discharges occurring on or after the date which is 90 days after the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4404(b), Aug. 5, 1997, 111 Stat. 400, provided that: ''The amendments made by subsection (a) [amending this section] apply to changes of ownership that occur after the third month beginning after the date of enactment of this section [Aug. 5, 1997].''

Amendment by section 4432(b)(5)(D), (E) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Pub. L. 105–33, title IV, § 4444(b), Aug. 5, 1997, 111 Stat. 423, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to items or services furnished on or after April 1, 1998.''

Amendment by sections 4445 and 4446 of Pub. L. 105–33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

Amendment by section 4454(a)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

Amendment by section 4511(a)(1)–(2)(B), (d) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4512(a) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4512(d) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Pub. L. 105–33, title IV, § 4513(b), Aug. 5, 1997, 111 Stat. 444, provided that: ''The amendment made by subsection (a) [amending this section] applies to services furnished on or after January 1, 2000.''

Pub. L. 105–33, title IV, § 4557(b), Aug. 5, 1997, 111 Stat. 463, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 1998.''

Pub. L. 105–33, title IV, § 4604(c), Aug. 5, 1997, 111 Stat. 472, provided that: ''The amendments made by this section [amending this section and section 1395bbb of this title] apply to cost reporting periods beginning on or after October 1, 1997.''

Amendment by section 4611(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

Pub. L. 105–33, title IV, § 4612(b), Aug. 5, 1997, 111 Stat. 474, provided that: ''The amendment made by subsection (a) [amending this section] applies to services furnished on or after October 1, 1997.''

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–299 effective Oct. 1, 1996, see section 5 of Pub. L. 104–299, as amended, set out as a note under section 233 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 107(b), Oct. 31, 1994, 108 Stat. 4407, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to servics furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act [Oct. 31, 1994].''

Amendment by section 145(b) of Pub. L. 103–432 applicable to mammography furnished by the facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Pub. L. 103–432, title I, § 146(c), Oct. 31, 1994, 108 Stat. 4429, provided that: ''The amendments made by this section [amending this section] shall take effect on January 1, 1995.''

Amendment by section 147(e)(1), (4), (5), (f)(3), (4)(A), (6)(A), (B), (E) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, § 158(a)(2), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after July 1, 1996.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13503(c)(2), Aug. 10, 1993, 107 Stat. 579, provided that: ''The amendments made by paragraph (1) [amending this section and section 1395*oo* of this title] shall take effect October 1, 1993.''

Pub. L. 103–66, title XIII, § 13553(c), Aug. 10, 1993, 107 Stat. 592, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall apply to items furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13554(b), Aug. 10, 1993, 107 Stat. 592, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13556(b), Aug. 10, 1993, 107 Stat. 592, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 4161(a)(2)(C) of OBRA–1990 [Pub. L. 101–508].''

Pub. L. 103–66, title XIII, § 13564(b)(2), Aug. 10, 1993, 107 Stat. 607, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1993.''

Pub. L. 103–66, title XIII, § 13566(c), Aug. 10, 1993, 107 Stat. 607, provided that: ''The amendments made by this section [amending this section and section 1395rr

of this title] shall apply to erythropoietin furnished on or after January 1, 1994.''

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(h)(2)(A)(i) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4008(h)(2)(P) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

Amendment by section 4152(a)(2) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4152(a)(3) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Pub. L. 101–508, title IV, §4153(b)(2)(C), Nov. 5, 1990, 104 Stat. 1388–84, provided that: ''The amendments made by subparagraphs (A) and (B) [amending this section and section 1395y of this title] shall apply to items furnished on or after January 1, 1991.''

Amendment by section 4155(a), (d) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4157(a) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(1), (2), (5) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, §4161(b)(5), Nov. 5, 1990, 104 Stat. 1388–95, provided that: ''This subsection [amending this section and section 1395*oo* of this title and enacting provisions set out as a note below] shall take effect on October 1, 1991, except that the amendment made by paragraph (4) [amending section 1395*oo* of this title] shall apply to cost reports for periods beginning on or after October 1, 1991.''

Amendment by section 4162(a) of Pub. L. 101–508 applicable with respect to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(a) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

Pub. L. 101–508, title IV, §4201(d)(3)[(4)], Nov. 5, 1990, 104 Stat. 1388–104, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and section 1395rr of this title] shall apply to items and services furnished on or after July 1, 1991.''

Pub. L. 101–508, title IV, §4207(d)(4), formerly §4027(d)(3), Nov. 5, 1990, 104 Stat. 1388–121, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (10), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to home health agency cost reporting periods beginning on or after July 1, 1991.''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6112(e)(1) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6112(e)(4) of Pub. L. 101–239, set out as a note under section 1395m of this title.

Amendment by section 6113(a)–(b)(2) of Pub. L. 101–239 applicable to services furnished on or after July 1, 1990, see section 6113(e) of Pub. L. 101–239, set out as a note under section 1395*l* of this title.

Amendment by section 6114(a), (d) of Pub. L. 101–239 applicable to services furnished on or after Apr. 1, 1990, see section 6114(f) of Pub. L. 101–239, set out as a note under section 1395u of this title.

Pub. L. 101–239, title VI, §6115(d), Dec. 19, 1989, 103 Stat. 2219, provided that: ''The amendments made by this section [amending this section and sections 1395y, 1395aa, 1395bb, 1396a, and 1396n of this title] shall apply to screening pap smears performed on or after July 1, 1990.''

Amendment by section 6131(a)(2) of Pub. L. 101–239 applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989, with additional provisions regarding applicability of the increase under section 1395*l*(*o*)(2)(C) of this title, see section 6131(c) of Pub. L. 101–239, set out as a note under section 1395*l* of this title.

Pub. L. 101–239, title VI, §6141(b), Dec. 19, 1989, 103 Stat. 2225, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

Pub. L. 101–239, title VI, §6213(d), Dec. 19, 1989, 103 Stat. 2251, as amended by Pub. L. 101–508, title IV, §4207(k)(4), formerly §4027(k)(4), Nov. 5, 1990, 104 Stat. 1388–125, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by subsections (a) through (c) of this section [amending this section] shall apply to services furnished on or after October 1, 1989.''

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

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8423(b), Nov. 10, 1988, 102 Stat. 3803, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after January 1, 1989.''

Pub. L. 100–647, title VIII, §8424(b), Nov. 10, 1988, 102 Stat. 3803, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective with respect to services provided after December 31, 1988.''

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(4) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 202(a) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(b), (e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(a) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(b) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Pub. L. 100–360, title II, §206(b), July 1, 1988, 102 Stat. 732, which provided that the amendment of this section by section 206(a) of Pub. L. 100–360 applied to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(5)(A), (g)(3)(H), (h)(1)(B)–(3)(A), (4)(D), (5)–(7)(A), (E), (F), (i)(3), (4)(C)(iii), (*l*)(1)(B), (C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act

of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, § 411(d)(1)(B)(ii), July 1, 1988, 102 Stat. 773, provided that: ''The amendment made by clause (i) [amending this section] shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA [Pub. L. 100–203, set out below].''

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4009(e)(2), Dec. 22, 1987, 101 Stat. 1330–58, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to services furnished on or after April 1, 1988.''

Pub. L. 100–203, title IV, § 4021(c), Dec. 22, 1987, 101 Stat. 1330–69, provided that: ''Except as otherwise provided, the amendments made by subsections (a) and (b) [enacting section 1395bbb of this title and amending this section] shall apply to home health agencies as of the first day of the 18th calendar month that begins after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4026(a)(2), Dec. 22, 1987, 101 Stat. 1330–75, as amended by Pub. L. 100–360, title IV, § 411(d)(5)(B), July 1, 1988, 102 Stat. 775, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 1989.''

Pub. L. 100–203, title IV, § 4064(e)(2), Dec. 22, 1987, 101 Stat. 1330–112, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to diagnostic tests performed on or after January 1, 1990.''

Pub. L. 100–203, title IV, § 4065(c), Dec. 22, 1987, 101 Stat. 1330–112, provided that: ''The amendments made by this section [amending this section and section 1395rr of this title] shall become effective on January 1, 1988.''

Pub. L. 100–203, title IV, § 4070(c)(2), Dec. 22, 1987, 101 Stat. 1330–115, provided that:

''(A) The amendments made by subsection (b) [amending this section and sections 1395*l* and 1395n of this title] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

''(B) The Secretary of Health and Human Services shall implement the amendments made by subsection (b) so as to ensure that there is no additional cost to the medicare program by reason of such amendments.''

Pub. L. 100–203, title IV, § 4071(b), Dec. 22, 1987, 101 Stat. 1330–116, provided that:

''(1) The provisions of subsection (e) of section 4072 of this subpart [section 4072(e) of Pub. L. 100–203, set out below] shall apply to this section [amending this section] in the same manner as it applies to section 4072. [Amendments became effective pursuant to final report dated Apr. 26, 1993. See Cong. Rec., vol. 139, pt. 7, p. 10460, Ex. Comm. 1254, May 19, 1993.]

''(2) In conducting the demonstration project pursuant to paragraph (1), in order to determine the cost effectiveness of including influenza vaccine in the medicare program, the Secretary of Health and Human Services is required to conduct a demonstration of the provision of influenza vaccine as a service for medicare beneficiaries and to expend $25,000,000 each year of the demonstration project for this purpose. In conducting this demonstration, the Secretary is authorized to purchase in bulk influenza vaccine and to distribute it in a manner to make it widely available to medicare beneficiaries, to develop projects to provide vaccine in the same manner as other covered medicare services in large scale demonstration projects, including statewide projects, and to engage in other appropriate use of moneys to provide influenza vaccine to medicare beneficiaries and evaluate the cost effectiveness of its use. In determining cost effectiveness, the Secretary shall consider the direct cost of the vaccine, the utilization of vaccine which might otherwise not have occurred, the costs of illnesses and nursing home days avoided, and other relevant factors, except that extended life for beneficiaries shall not be considered to reduce the cost effectiveness of the vaccine.''

Pub. L. 100–203, title IV, § 4072(e), Dec. 22, 1987, 101 Stat. 1330–117, provided that:

''(1) The amendments made by this section [amending this section and sections 1395*l*, 1395y, 1395aa, 1395bb, 1396a, and 1396n of this title] shall become effective (if at all) in accordance with paragraph (2).

''(2)(A) The Secretary of Health and Human Services (in this paragraph referred to as the 'Secretary'), shall establish a demonstration project to begin on October 1, 1988, to test the cost-effectiveness of furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section to a sample group of medicare beneficiaries.

''(B)(i) The demonstration project under subparagraph (A) shall be conducted for an initial period of 24 months. Not later than October 1, 1990, the Secretary shall report to the Congress on the results of such project. If the Secretary finds, on the basis of existing data, that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is cost-effective, the Secretary shall include such finding in such report, such project shall be discontinued, and the amendments made by this section shall become effective on November 1, 1990.

''(ii) If the Secretary determines that such finding cannot be made on the basis of existing data, such project shall continue for an additional 24 months. Not later than April 1, 1993, the Secretary shall submit a final report to the Congress on the results of such project. The amendments made by this section shall become effective on the first day of the first month to begin after such report is submitted to the Congress unless the report contains a finding by the Secretary that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is not cost-effective (in which case the amendments made by this section shall not become effective).''

[Amendments by section 4072 of Pub. L. 100–203 became effective pursuant to final report dated Apr. 26, 1993. See Cong. Rec., vol. 139, pt. 7, p. 10460, Ex. Comm. 1252, May 19, 1993.]

Amendment by section 4073(a), (c) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Pub. L. 100–203, title IV, § 4074(c), Dec. 22, 1987, 101 Stat. 1330–120, provided that: ''The amendments made by this section [amending this section] shall be effective with respect to services performed on or after January 1, 1988.''

Pub. L. 100–203, title IV, § 4075(b), Dec. 22, 1987, 101 Stat. 1330–120, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to drugs dispensed on or after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4076(b), Dec. 22, 1987, 101 Stat. 1330–120, provided that: ''The amendments made by this section [amending this section] shall apply with respect to services furnished on or after January 1, 1989.''

Pub. L. 100–203, title IV, § 4077(a)(2), Dec. 22, 1987, 101 Stat. 1330–120, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective with respect to services furnished on or after the date of enactment of this Act [Dec. 22, 1987].''

Amendment by section 4077(b)(1), (4) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4077(b)(5) of Pub. L. 100–203, as amended, set out as a note under section 1395k of this title.

Amendment by section 4084(c)(1) of Pub. L. 100–203 applicable to services furnished after Dec. 31, 1988, see section 4084(c)(3) of Pub. L. 100–203, as added, set out as a note under section 1395*l* of this title.

Amendments by section 4201(a)(1), (b)(1), (d)(1), (2), (5) of Pub. L. 100–203 applicable to services furnished on or

after Oct. 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9305(c)(4), Oct. 21, 1986, 100 Stat. 1990, provided that: ''The amendments made by this subsection [amending this section and section 1395bb of this title] shall apply to hospitals as of one year after the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–509, title IX, §9313(a)(3), Oct. 21, 1986, 100 Stat. 2002, provided that: ''The amendments made by this paragraph [probably means ''this subsection'' which amended this section and section 1395ff of this title] take effect on the date of the enactment of this Act [Oct. 21, 1986].''

Amendment by section 9320(b), (c), (f) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9335(c)(2), Oct. 21, 1986, 100 Stat. 2030, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to immunosuppressive drugs furnished on or after January 1, 1987.''

Pub. L. 99–509, title IX, §9336(b), Oct. 21, 1986, 100 Stat. 2033, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1987.''

Amendment by section 9337(d) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Pub. L. 99–509, title IX, §9338(f), Oct. 21, 1986, 100 Stat. 2036, provided that: ''The amendments made by this section [amending this section and section 1395u of this title] shall apply to services furnished on or after January 1, 1987.''

Pub. L. 99–272, title IX, §9107(c)(2), Apr. 7, 1986, 100 Stat. 161, provided that: ''The amendments made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985.''

Pub. L. 99–272, title IX, §9110(b), Apr. 7, 1986, 100 Stat. 162, provided that: ''The amendments made by subsection (a) [amending this section] shall be applied as though they were originally included in the Deficit Reduction Act of 1984 [Pub. L. 98–369].''

Pub. L. 99–272, title IX, §9202(i)(2), Apr. 7, 1986, 100 Stat. 177, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 1985.''

Amendment by section 9219(b)(1)(B) of Pub. L. 99–272 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 9219(b)(1)(D) of Pub. L. 99–272, set out as a note under section 1395u of this title.

Pub. L. 99–272, title IX, §9219(b)(3)(B), Apr. 7, 1986, 100 Stat. 183, provided that: ''The amendment made by subparagraph (A) [amending this section] shall be effective as if it had been originally included in the Social Security Amendments of 1983 [Pub. L. 98–21].''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2314(c)(1), (2), July 18, 1984, 98 Stat. 1079, provided that:

''(1) Clause (i) of section 1861(v)(1)(O) of the Social Security Act [42 U.S.C. 1395x(v)(1)(O)(i)] shall not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before the date of the enactment of this Act [July 18, 1984].

''(2) Clause (iii) of section 1861(v)(1)(O) of such Act [42 U.S.C. 1395x(v)(1)(O)(iii)] shall apply to costs incurred on or after the date of the enactment of this Act.''

Pub. L. 98–369, div. B, title III, §2318(c), July 18, 1984, 98 Stat. 1082, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2319(a) of Pub. L. 98–369 applicable to cost reporting periods beginning on or after July 1, 1984, see section 2319(c) of Pub. L. 98–369, set out as an Effective Date note under section 1395yy of this title.

Amendment by section 2321(e) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2322(b), July 18, 1984, 98 Stat. 1086, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2323(a) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Pub. L. 98–369, div. B, title III, §2324(b), July 18, 1984, 98 Stat. 1087, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective with respect to items and services purchased on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2335(b) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2340(c), July 18, 1984, 98 Stat. 1093, provided that: ''The amendments made by this section [amending this section and section 1396d of this title] shall become effective on the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2341(a), (c) of Pub. L. 98–369 applicable to services furnished on or after July 18, 1984, see section 2341(d) of Pub. L. 98–369, set out as a note under section 1395k of this title.

Amendment by section 2342(a) of Pub. L. 98–369 applicable to plans of care established on or after July 18, 1984, see section 2342(c) of Pub. L. 98–369, set out as a note under section 1395n of this title.

Pub. L. 98–369, div. B, title III, §2343(c), July 18, 1984, 98 Stat. 1095, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(18)–(29) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 602(d) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97–448 effective as if originally included in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, to which such amendment relates, see section 309(c)(1) of Pub. L. 97–448, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 101(a)(2) of Pub. L. 97–248 applicable to cost reporting periods beginning on or after Oct. 1, 1982, see section 101(b)(1) of Pub. L. 97–248, set out as an Effective Date note under section 1395ww of this title.

Pub. L. 97–248, title I, § 102(b), Sept. 3, 1982, 96 Stat. 336, as amended by Pub. L. 98–21, title VI, § 605(a), Apr. 20, 1983, 97 Stat. 169, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1983.''

Pub. L. 97–248, title I, § 103(b), Sept. 3, 1982, 96 Stat. 336, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to a hospital or skilled nursing facility resulting from such amendment shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.''

Pub. L. 97–248, title I, § 105(b), Sept. 3, 1982, 96 Stat. 337, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after the date of the enactment of this Act [Sept. 3, 1982].''

Pub. L. 97–248, title I, § 106(b), Sept. 3, 1982, 96 Stat. 337, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to any costs incurred under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act [Sept. 3, 1982] pursuant to the final court order affirmed by a United States Court of Appeals.''

Pub. L. 97–248, title I, § 107(b), Sept. 3, 1982, 96 Stat. 337, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to costs incurred after the date of the enactment of this Act [Sept. 3, 1982].''

Amendment by section 109(b)(2) of Pub. L. 97–248 effective Sept. 3, 1982, see section 109(c)(1) of Pub. L. 97–248, set out as a note under section 1395xx of this title.

Pub. L. 97–248, title I, § 109(c)(3), Sept. 3, 1982, 96 Stat. 339, provided that: ''The amendment made by subsection (b)(1) [amending this section] shall not apply to contracts entered into before the date of the enactment of this Act [Sept. 3, 1982].''

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

Pub. L. 97–248, title I, § 128(e), Sept. 3, 1982, 96 Stat. 367, as amended by Pub. L. 99–514, § 2, Oct. 22, 1986, 100 Stat. 2095, provided that:

''(1) Any amendment to the Omnibus Budget Reconciliaton [Reconciliation] Act of 1981 [Pub. L. 97–35] made by this section [amending provisions set out as notes under sections 426 and 1395x of this title] shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

''(2) Except as otherwise provided in this section, any amendment to the Social Security Act [42 U.S.C. 301 et seq.] or the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [Title 26, Internal Revenue Code] made by this section (other than subsection (d)) [amending this section and sections 1395y, 1395cc, and 1395uu of this title and section 162 of Title 26] shall be effective as if it had been originally included as a part of that provision of the Social Security Act or Internal Revenue Code of 1986 to which it relates, as such provision of such Act or Code was amended by the Omnibus Budget Reconciliaton [Reconciliation] Act of 1981 [Pub. L. 97–35].

''(3) The amendments made by subsection (d) [amending this section and sections 1395u, 1395bb, 1395cc, and 1395gg of this title] shall take effect upon enactment [Sept. 3, 1982].''

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

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, § 2102(b)(1), Aug. 13, 1981, 95 Stat. 787, provided that: ''The amendments made by subsection (a) [amending this section], shall apply to services provided on or after the first day of the first month beginning after the date of the enactment of this Act [Aug. 13, 1981].''

Amendment by section 2121(c), (d) of Pub. L. 97–35 applicable to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after Aug. 13, 1981, see section 2121(i) of Pub. L. 97–35, set out as a note under section 1395d of this title.

Pub. L. 97–35, title XXI, § 2141(c), Aug. 13, 1981, 95 Stat. 798, provided that:

''(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

''(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.''

Pub. L. 97–35, title XXI, § 2143(b), Aug. 13, 1981, 95 Stat. 799, as amended by Pub. L. 97–248, title I, § 128(c)(1), Sept. 3, 1982, 96 Stat. 367, provided that:

''(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

''(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.''

Pub. L. 97–35, title XXI, § 2144(b), Aug. 13, 1981, 95 Stat. 799, provided that:

''(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

''(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.''

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395*l* of this title.

Pub. L. 96–499, title IX, § 902(c), Dec. 5, 1980, 94 Stat. 2614, provided that: ''The amendments made by this section [amending this section and sections 1320c–7 and 1396a of this title] shall become effective on the date of [probably should be ''on''] which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980].''

Pub. L. 96–499, title IX, § 930(s), Dec. 5, 1980, 94 Stat. 2633, provided that:

''(1) the amendments made by this section [amending this section, sections 426, 1395c, 1395d, 1395f, 1395h, 1395k, 1395*l*, and 1395n of this title, and section 231f of Title 45, Railroads, and repealing section 1395m of this

title] shall become effective with respect to services furnished on or after July 1, 1981, except that the amendments made by subsections (n)(1) and (*o*) [amending this section and section 1395h of this title] shall become effective on the date of the enactment of this Act [Dec. 5, 1980].

''(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1) [amending this section], will be made not later than June 30, 1981.''

Amendment by section 931(c), (d) of Pub. L. 96–499 effective Apr. 1, 1981, see section 931(e) of Pub. L. 96–499, set out as a note under section 1395d of this title.

Amendment by section 933(c)–(e) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

Amendment by section 936(a) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Pub. L. 96–499, title IX, §937(c), Dec. 5, 1980, 94 Stat. 2640, as amended by Pub. L. 98–369, div. B, title III, §2354(c)(1)(B), July 18, 1984, 98 Stat. 1102, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 1981.''

Pub. L. 96–499, title IX, §938(b), Dec. 5, 1980, 94 Stat. 2640, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1981.''

Pub. L. 96–499, title IX, §948(c)(1), Dec. 5, 1980, 94 Stat. 2644, provided that: ''The amendments made by subsection (a) [amending this section and section 1395k of this title] shall apply with respect to cost accounting periods beginning on or after October 1, 1978. A hospital's election under section 1861(b)(7)(A) of the Social Security Act [42 U.S.C. 1395x(b)(7)(A)] (as administered in accordance with section 15 of Public Law 93–233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by subsection (a)(1)) on and after October 1, 1978, until otherwise provided by the hospital.''

Pub. L. 96–499, title IX, §951(c), Dec. 5, 1980, 94 Stat. 2646, provided that: ''The amendments made by this section [amending this section] shall take effect on January 1, 1981.''

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title V, §501(c), Dec. 20, 1977, 91 Stat. 1565, provided that: ''The amendments made by this section [amending this section and section 1395u of this title] shall be effective in the case of items and services furnished after the date of the enactment of this Act [Dec. 20, 1977].''

Amendment by Pub. L. 95–210 applicable to services rendered on or after the first day of the third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Amendment by section 3(a)(2) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 19(b)(1) of Pub. L. 95–142 effective with respect to operation of a hospital, skilled nursing facility, or intermediate care facility on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established under section 1320a(a) of this title for that type of health services facility, except that for other types of facilities or organizations effective with respect to operations on and after the first day of its first fiscal year which begins after such date as the Secretary determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization, see section 19(c)(2) of Pub. L. 95–142, set out as a note under section 1396a of this title.

Pub. L. 95–142, §21(c)(1), Oct. 25, 1977, 91 Stat. 1208, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective on the first day of the first calendar quarter which begins more than six months after the date of enactment of this Act [Oct. 25, 1977].''

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §106(b), Dec. 31, 1975, 89 Stat. 1052, provided that: ''Subject to subsection (c) [enacting provisions set out below], the amendment made by subsection (a) [amending this section] shall be effective on the first day of the sixth month which begins after the date of enactment of this Act [Dec. 31, 1975].''

Pub. L. 94–182, title I, §112(d), Dec. 31, 1975, 89 Stat. 1055, provided that: ''The amendments made by this section [amending this section and sections 1320c–17 and 1395g of this title] shall be effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after the date of enactment of this Act [Dec. 31, 1975].''

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(b), (c)(2) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Pub. L. 92–603, title II, §223(h), Oct. 31, 1972, 86 Stat. 1394, provided that: ''The amendments made by this section [amending this section and section 1395cc of this title] shall be effective with respect to accounting periods beginning after December 31, 1972.''

Pub. L. 92–603, title II, §227(g), Oct. 31, 1972, 86 Stat. 1407, provided that: ''The amendments made by this section [amending this section and sections 1395f, 1395k, 1395n, 1395u, and 1395cc of this title] shall apply with respect to accounting periods beginning after June 30, 1973.''

Pub. L. 92–603, title II, §234(i), Oct. 31, 1972, 86 Stat. 1414, provided that: ''The amendments made by this section [amending this section and sections 1395f, 1395z, and 1395bb of this title] shall apply with respect to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month in which this Act is enacted [October 1972].''

Pub. L. 92–603, title II, §246(c), Oct. 31, 1972, 86 Stat. 1425, provided that: ''The amendments made by this section [amending this section and section 1396 of this title] shall be effective July 1, 1973.''

Pub. L. 92–603, title II, §251(d), Oct. 31, 1972, 86 Stat. 1446, as amended by Pub. L. 93–233, §17(a), Dec. 31, 1973, 87 Stat. 967, provided that:

''(1) The amendments made by subsection (a) [amending this section and sections 1395*l* and 1395k of this title] shall apply with respect to services furnished on or after July 1, 1973.

''(2) The amendments made by subsection (b) [amending this section and section 1395n of this title] shall apply with respect to services furnished on or after the date of enactment of this Act [Oct. 30, 1972].

''(3) The amendments made by subsection (c) [amending this section] shall be effective with respect to accounting periods beginning after the month in which there are promulgated, by the Secretary of Health, Education, and Welfare, final regulations implementing the provisions of section 1861(v)(5) of the Social Security Act [42 U.S.C. 1395x(v)(5)].''

Pub. L. 92–603, title II, § 252(b), Oct. 31, 1972, 86 Stat. 1446, provided that: ''The amendment made by subsection (a) [amending this section] shall apply only with respect to items furnished on or after the date of the enactment of this Act [Oct. 30, 1972].''

Amendment by section 256(b) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Pub. L. 92–603, title II, § 264(b), Oct. 31, 1972, 86 Stat. 1449, provided that: ''The amendment made by subsection (a) [amending this section] shall apply only with respect to services performed on or after the date of the enactment of this Act [Oct. 30, 1972].''

Pub. L. 92–603, title II, § 273(b), Oct. 31, 1972, 86 Stat. 1452, provided that: ''The amendments made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973.''

Pub. L. 92–603, title II, § 276(b), Oct. 31, 1972, 86 Stat. 1452, provided that: ''The amendment made by this section [amending this section] shall apply with respect to accounting periods beginning after December 31, 1972.''

Amendment by section 283(a) of Pub. L. 92–603 to apply with respect to services rendered after Dec. 31, 1972, see section 283(c) of Pub. L. 92–603, set out as a note under section 1395n of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, § 127(c), Jan. 2, 1968, 81 Stat. 847, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1395y of this title] shall apply with respect to services furnished after December 31, 1967.''

Amendment by section 129(a), (b), (c)(9)(C), (10), (11) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 132(a) of Pub. L. 90–248 applicable with respect to items purchased after Dec. 31, 1967, see section 132(c) of Pub. L. 90–248, set out as a note under section 1395*l* of this title.

Amendment by section 133(a), (b) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Pub. L. 90–248, title I, § 134(b), Jan. 2, 1968, 81 Stat. 852, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished after December 31, 1967.''

Amendment by section 143(a) of Pub. L. 90–248 effective July 1, 1966, see section 143(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, § 144(e), Jan. 2, 1968, 81 Stat. 859, provided that: ''The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968.''

EFFECTIVE DATE OF 1966 AMENDMENT

Amendment by Pub. L. 89–713 effective Nov. 2, 1966, see section 6 of Pub. L. 89–713, set out as a note under section 6091 of Title 26, Internal Revenue Code.

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title II, § 2002(c), Oct. 24, 2018, 132 Stat. 3926, provided that: ''Nothing in the amendments made by subsection (a) or (b) [amending this section] shall be construed to prohibit separate payment for structured assessment and intervention services for substance abuse furnished to an individual on the same day as an initial preventive physical examination or an annual wellness visit.''

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 153(b)(3)(B) of Pub. L. 110–275, see section 153(b)(4) of Pub. L. 110–275, set out as a note under section 1395rr of this title.

IMPLEMENTATION

Pub. L. 116–260, div. CC, title I, § 117(c), Dec. 27, 2020, 134 Stat. 2950, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by subsection (a) [amending this section] by interim final rule, program instruction, or otherwise.''

CONFORMING REFERENCES TO PREVIOUS PART D

Pub. L. 108–173, title I, § 101(e)(1), Dec. 8, 2003, 117 Stat. 2150, provided that: ''Any reference in law (in effect before the date of the enactment of this Act [Dec. 8, 2003]) to part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] is deemed a reference to part E of such title [42 U.S.C. 1395x et seq.] (as in effect after such date).''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT

Pub. L. 108–173, title IV, § 434, Dec. 8, 2003, 117 Stat. 2288, provided that:

''(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary [of Health and Human Services] shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

''(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

''(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

''(2) is designed to address the needs of—

''(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

''(B) patients who need monitoring and observation for a limited period of time.

''(c) SPECIFICATION OF CODES.—The Secretary shall determine the appropriate life-safety codes for such clinics that treat patients for needs referred to in subsection (b)(2).

''(d) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), there are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary to conduct the demonstration project under this section.

''(2) BUDGET NEUTRAL IMPLEMENTATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration project under this section was not implemented.

''(e) THREE-YEAR PERIOD.—The Secretary shall conduct the demonstration under this section for a 3-year period.

''(f) REPORT.—Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the demonstration project, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(g) DEFINITIONS.—In this section, the terms 'hospital' and 'critical access hospital' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).''

MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

Pub. L. 108–173, title VI, §643, Dec. 8, 2003, 117 Stat. 2322, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

''(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

''(c) DEFINITIONS.—In this section:

''(1) SURGICAL FIRST ASSISTING SERVICES.—The term 'surgical first assisting services' means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary [of Health and Human Services]) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

''(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term 'certified registered nurse first assistant' means an individual who—

''(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

''(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

''(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.''

STUDIES RELATING TO VISION IMPAIRMENTS

Pub. L. 108–173, title VI, §645, Dec. 8, 2003, 117 Stat. 2323, provided that:

''(a) COVERAGE OF OUTPATIENT VISION SERVICES FURNISHED BY VISION REHABILITATION PROFESSIONALS UNDER PART B.—

''(1) STUDY.—The Secretary [of Health and Human Services] shall conduct a study to determine the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals.

''(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

''(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term 'vision rehabilitation professional' means an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist.

''(b) REPORT ON APPROPRIATENESS OF A DEMONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYEGLASSES FOR MEDICARE BENEFICIARIES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall submit to Congress a report on the feasibility of establishing a two-year demonstration project under which the Secretary enters into arrangements with vision care preferred provider organization networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with insertion of an intraocular lens on behalf of Medicare beneficiaries. In such report, the Secretary shall include an estimate of potential cost savings to the Medicare program through the use of such networks, taking into consideration quality of service and beneficiary access to services offered by vision care preferred provider organization networks.''

DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE

Pub. L. 108–173, title VI, §651, Dec. 8, 2003, 117 Stat. 2332, provided that:

''(a) DEFINITIONS.—In this section:

''(1) CHIROPRACTIC SERVICES.—The term 'chiropractic services' has the meaning given that term by the Secretary [of Health and Human Services] for purposes of the demonstration projects, but shall include, at a minimum—

''(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

''(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

''(2) DEMONSTRATION PROJECT.—The term 'demonstration project' means a demonstration project established by the Secretary under subsection (b)(1).

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is enrolled under part B of the medicare program.

''(4) MEDICARE PROGRAM.—The term 'medicare program' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

''(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

''(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

''(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

''(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

''(c) CONDUCT OF DEMONSTRATION PROJECTS.—

''(1) DEMONSTRATION SITES.—

''(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 4 demonstration sites.

''(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

''(i) two shall be in rural areas; and

''(ii) two shall be in urban areas.

''(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

''(2) IMPLEMENTATION; DURATION.—

''(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

''(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 2 years after the date on which the first demonstration project is implemented.

''(d) EVALUATION AND REPORT.—

''(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

''(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

''(B) to determine the cost of providing payment for chiropractic services under the medicare program;

''(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

''(D) to evaluate such other matters as the Secretary determines is appropriate.

''(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

''(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

''(f) FUNDING.—

''(1) DEMONSTRATION PROJECTS.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

''(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

''(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).''

DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND

Pub. L. 108–173, title VII, §702, Dec. 8, 2003, 117 Stat. 2335, provided that:

''(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall conduct a 2-year demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

''(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

''(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve;

''(2) the beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the beneficiary's life;

''(3) the beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management;

''(4) an attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living;

''(5) the beneficiary requires technological assistance or the assistance of another person to leave the home; and

''(6) the beneficiary does not regularly work in a paid position full-time or part-time outside the home.

''(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

''(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

''(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

''(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e). The report shall include the following:

''(1) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

''(A) Has adversely affected the provision of home health services under the medicare program.

''(B) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

''(2) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

''(3) Specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs to the medicare program.

''(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act [42 U.S.C. 1395 et seq., 1301 et seq.] for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

''(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

''(j) DEFINITIONS.—In this section:

''(1) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].

''(2) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

''(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term 'activities of daily living' means eating, toileting, transferring, bathing, and dressing.''

INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS

Pub. L. 108–173, title IX, §926(a), Dec. 8, 2003, 117 Stat. 2396, provided that: ''The Secretary [of Health and Human Services] shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.''

IMPLEMENTATION OF AMENDMENTS BY PUB. L. 105–277

Pub. L. 105–277, div. J, title V, §5101(i), Oct. 21, 1998, 112 Stat. 2681–916, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall promptly issue (without regard to chapter 8 of title 5, United States Code) such regulations or program memoranda as may be necessary to effect the amendments made by this section [amending this section, sections 1395r and 1395fff of this title, and provisions set out as notes under section 1395fff of this title] for cost reporting periods beginning during fiscal year 1999.

''(2) USE OF PAYMENT AMOUNTS AND LIMITS FROM PUBLISHED TABLES.—

''(A) PER BENEFICIARY LIMITS.—In effecting the amendments made by subsection (a) [amending this section] for cost reporting periods beginning in fiscal year 1999, the 'median' referred to in section 1861(v)(1)(L)(vi)(I) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)(vi)(I)] for such periods shall be the national standardized per beneficiary limitation specified in Table 3C published in the Federal Register on August 11, 1998 (63 FR 42926) and the 'standardized regional average of such costs' referred to in section 1861(v)(1)(L)(v)(I) of such Act [42 U.S.C. 1395x(v)(1)(L)(v)(I)] for a census division shall be the sum of the labor and nonlabor components of the standardized per beneficiary limitation for that census division specified in Table 3B published in the Federal Register on that date (63 FR 42926) (or in Table 3D as so published with respect to Puerto Rico and Guam), and adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on that date (63 FR 42926–42933).

''(B) PER VISIT LIMITS.—In effecting the amendments made by subsection (b) [amending this section] for cost reporting periods beginning in fiscal year 1999, the limits determined under section 1861(v)(1)(L)(i)(V) of such Act [42 U.S.C. 1395x(v)(1)(L)(i)(V)] for cost reporting periods beginning during such fiscal year shall be equal to the per visit limits as specified in Table 3A published in the Federal Register on August 11, 1998 (63 FR 42925) and as subsequently corrected, multiplied by $^{106}/_{105}$, and adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on August 11, 1998 (63 FR 42926–42933).''

STUDY ON EXPANSION OF MEDICAL NUTRITION THERAPY SERVICES BENEFIT

Pub. L. 106–554, §1(a)(6) [title I, §105(f)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, provided that: ''Not later than July 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report that contains recommendations with respect to the expansion to other medicare beneficiary populations of the medical nutrition therapy services benefit (furnished under the amendments made by this section [amending this section and sections 1395*l* and 1395u of this title]).''

STUDY ON MEDICARE COVERAGE OF ROUTINE THYROID SCREENING

Pub. L. 106–554, §1(a)(6) [title I, §123], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, provided that:

''(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to conduct a study on the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit provided to medicare beneficiaries under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for some or all medicare beneficiaries. In conducting the study, the Academy shall consider the short-term and long-term benefits, and costs to the medicare program, of such addition.

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit a report on the findings of the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate.''

GAO STUDY ON COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

Pub. L. 106–554, §1(a)(6) [title IV, §433], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effect on the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and on medicare beneficiaries of coverage under the program of surgical first assisting services of certified registered nurse first assistants. The Comptroller General shall consider the following when conducting the study:

''(1) Any impact on the quality of care furnished to medicare beneficiaries by reason of such coverage.

''(2) Appropriate education and training requirements for certified registered nurse first assistants who furnish such first assisting services.

''(3) Appropriate rates of payment under the program to such certified registered nurse first assistants for furnishing such services, taking into account the costs of compensation, overhead, and supervision attributable to certified registered nurse first assistants.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a).''

MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF SERVICES PROVIDED BY CERTAIN NONPHYSICIAN PROVIDERS

Pub. L. 106–554, §1(a)(6) [title IV, §435], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study to determine the appropriateness of providing coverage under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services provided by a—

''(A) surgical technologist;

''(B) marriage counselor;

''(C) marriage and family therapist;

''(D) pastoral care counselor; and

''(E) licensed professional counselor of mental health.

''(2) COSTS TO PROGRAM.—The study shall consider the short-term and long-term benefits, and costs to the medicare program, of providing the coverage described in paragraph (1).

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.''

DEVELOPMENT OF PATIENT ASSESSMENT INSTRUMENTS

Pub. L. 106–554, §1(a)(6) [title V, §545], Dec. 21, 2000, 114 Stat. 2763, 2763A–551, provided that:

''(a) DEVELOPMENT.—

''(1) IN GENERAL.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate a report on the development of standard instruments for the assessment of the health and functional status of patients, for whom items and services described in subsection (b) are furnished, and include in the report a recommendation on the use of such standard instruments for payment purposes.

''(2) DESIGN FOR COMPARISON OF COMMON ELEMENTS.—The Secretary shall design such standard instruments in a manner such that—

''(A) elements that are common to the items and services described in subsection (b) may be readily comparable and are statistically compatible;

''(B) only elements necessary to meet program objectives are collected; and

''(C) the standard instruments supersede any other assessment instrument used before that date.

''(3) CONSULTATION.—In developing an assessment instrument under paragraph (1), the Secretary shall consult with the Medicare Payment Advisory Commission, the Agency for Healthcare Research and Quality, and qualified organizations representing providers of services and suppliers under title XVIII [42 U.S.C. 1395 et seq.].

''(b) DESCRIPTION OF SERVICES.—For purposes of subsection (a), items and services described in this subsection are those items and services furnished to individuals entitled to benefits under part A, or enrolled under part B, or both of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for which payment is made under such title [42 U.S.C. 1395 et seq.], and include the following:

''(1) Inpatient and outpatient hospital services.

''(2) Inpatient and outpatient rehabilitation services.

''(3) Covered skilled nursing facility services.

''(4) Home health services.

''(5) Physical or occupational therapy or speech-language pathology services.

''(6) Items and services furnished to such individuals determined to have end stage renal disease.

''(7) Partial hospitalization services and other mental health services.

''(8) Any other service for which payment is made under such title as the Secretary determines to be appropriate.''

CONFORMING REFERENCES TO PREVIOUS PART C

Pub. L. 105–33, title IV, §4002(f)(1), Aug. 5, 1997, 111 Stat. 329, provided that: ''Any reference in law (in effect before the date of the enactment of this Act [Aug. 5, 1997]) to part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] is deemed a reference to part D of such title [42 U.S.C. 1395w–101 et seq.] (as in effect after such date).''

DEADLINE FOR PUBLICATION OF DETERMINATION ON COVERAGE OF SCREENING BARIUM ENEMA

Pub. L. 105–33, title IV, §4104(a)(2), Aug. 5, 1997, 111 Stat. 363, provided that: ''Not later than the earlier of the date that is January 1, 1998, or 90 days after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall publish notice in the Federal Register with respect to the determination under paragraph (1)(D) of section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)), as added by paragraph (1), on the coverage of a screening barium enema as a colorectal cancer screening test under such section.''

ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES

Pub. L. 105–33, title IV, §4105(c), Aug. 5, 1997, 111 Stat. 367, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

''(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under paragraph (1), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.''

VACCINES OUTREACH EXPANSION

Pub. L. 105–33, title IV, §4107, Aug. 5, 1997, 111 Stat. 368, provided that:

''(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

''(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each of fiscal years 1998 through 2002, $8,000,000 for the Campaign described in subsection (a). Of the amount so authorized to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''

STUDY ON PREVENTIVE AND ENHANCED BENEFITS

Pub. L. 105–33, title IV, §4108, Aug. 5, 1997, 111 Stat. 369, directed the Secretary of Health and Human Services to request the National Academy of Sciences to analyze the expansion or modification of preventive or other benefits provided to medicare beneficiaries under this subchapter, and not later than 2 years after Aug. 5, 1997, to submit a report on the findings of the analysis to Congress.

UTILIZATION GUIDELINES

Pub. L. 105–33, title IV, §4513(c), Aug. 5, 1997, 111 Stat. 444, provided that: ''The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in cases in which a subluxation has not been demonstrated by X-ray to exist.''

AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES

Pub. L. 105–33, title IV, § 4531(c), Aug. 5, 1997, 111 Stat. 452, as amended by Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 412(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, provided that: ''In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as 'ALS intercept services') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

''(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

''(2) The volunteer ambulance service involved—

''(A) is certified as qualified to provide ambulance service for purposes of such section,

''(B) provides only basic life support services at the time of the intercept, and

''(C) is prohibited by State law from billing for any services.

''(3) The entity supplying the ALS intercept services—

''(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and

''(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).''

[Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 412(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, provided that: ''The amendment made by subsection (a) [amending section 4531(c) of Pub. L. 105–33, set out above] takes effect on January 1, 2000, and applies to ALS intercept services furnished on or after such date.'']

NO EXCEPTIONS PERMITTED BASED ON AMENDMENT TO SUBSECTION (v)(1)(L)

Pub. L. 105–33, title IV, § 4601(b), Aug. 5, 1997, 111 Stat. 466, provided that: ''The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) [amending this section] in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).''

STUDY ON DEFINITION OF HOMEBOUND

Pub. L. 105–33, title IV, § 4613, Aug. 5, 1997, 111 Stat. 474, provided that:

''(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

''(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.''

REVISIONS OF COVERAGE FOR IMMUNOSUPPRESSIVE DRUG THERAPY

Pub. L. 103–432, title I, § 160(c), Oct. 31, 1994, 108 Stat. 4443, provided that: ''The Secretary of Health and Human Services may administer section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) in a manner such that the months of coverage of drugs described in such section are provided consecutively, so long as the total number of months of coverage provided is the same as the number of months described in such section.''

FREEZE IN PER VISIT COST LIMITS FOR HOME HEALTH SERVICES

Pub. L. 103–66, title XIII, § 13564(a)(1), Aug. 10, 1993, 107 Stat. 607, provided that: ''The Secretary of Health and Human Services shall not provide for any change in the per visit cost limits for home health services under section 1861(v)(1)(L) of such Act [42 U.S.C. 1395x(v)(1)(L)] for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, except as may be necessary to take into account the amendment made by subsection (b)(1) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1861(v)(1)(L)(ii) of such Act to the payment limits for such services during such cost reporting periods.''

STUDY AND REPORT ON EFFECTS OF COVERAGE OF OSTEOPOROSIS DRUGS

Pub. L. 101–508, title IV, § 4156(b), Nov. 5, 1990, 104 Stat. 1388–88, directed Secretary of Health and Human Services to conduct a study analyzing effects of coverage of osteoporosis drugs under part B of this subchapter on health of individuals enrolled under such part and utilization of inpatient hospital and extended care services by such individuals, and, by not later than Oct. 1, 1994, to submit a report to Congress on such study, which was to include recommendations regarding expansion of coverage under the medicare program of items and services for individuals with postmenopausal osteoporosis as the Secretary considered appropriate.

PRODUCTIVITY SCREENING GUIDELINES APPLICATION TO STAFF IN RURAL HEALTH CLINICS

Pub. L. 101–508, title IV, § 4161(b)(3), Nov. 5, 1990, 104 Stat. 1388–95, provided that: ''In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioner).''

DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES

Pub. L. 101–508, title IV, § 4207(c), formerly § 4027(c), Nov. 5, 1990, 104 Stat. 1388–119, as renumbered and amended by Pub. L. 103–432, title I, § 160(d)(4), (9), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–362, title VI, § 601(b)(2), Nov. 10, 1998, 112 Stat. 3286, directed Secretary of Health and Human Services to develop a proposal to modify the current system under which payment is made for home health services under this subchapter or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates, with Secretary to submit to Congress by not later than Apr. 1, 1993, the research findings upon which the proposal was to be based, and directed Prospective Payment Assessment Commission to submit to Congress by not later than Mar. 1, 1994, an analysis of and comments on the proposal.

APPLICATION OF BUDGET-NEUTRAL BASIS

Pub. L. 101–508, title IV, § 4207(d)(2), formerly § 4027(d)(2), Nov. 5, 1990, 104 Stat. 1388–120, as renumbered by Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: ''In updating the wage index for establishing limits under section 1861(v)(1)(L)(iii) of the Social Security Act [42 U.S.C.

1395x(v)(1)(L)(iii)], the Secretary shall ensure that aggregate payments to home health agencies under title XVIII of such Act [42 U.S.C. 1395 et seq.] will be no greater or lesser than such payments would have been without regard to such update.''

TRANSITION PROVISIONS FOR DETERMINING REASONABLE COSTS FOR HOME HEALTH AGENCY SERVICES

Pub. L. 101–508, title IV, § 4207(d)(3), formerly § 4027(d)(3), Nov. 5, 1990, 104 Stat. 1388–121, as renumbered by Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that, notwithstanding subsec. (v)(1)(L)(iii) of this section, the Secretary of Health and Human Services was to, in determining the limits of reasonable costs under this subchapter with respect to services furnished by a home health agency, utilize a wage index equal to (1) for cost reporting periods beginning on or after July 1, 1991, and on or before June 30, 1992, a combined area wage index consisting of 67 percent of the area wage index applicable to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States, and 33 percent of the area wage index applicable to hospitals located in the geographic area in which the home health agency was located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States, and (2) for cost reporting periods beginning on or after July 1, 1992, and on or before June 30, 1993, a combined area wage index consisting of 33 percent of the area wage index applicable to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States, and 67 percent of the area wage index applicable to hospitals located in the geographic area in which the home health agency was located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States.

PERMITTING DENTIST TO SERVE AS HOSPITAL MEDICAL DIRECTOR

Pub. L. 101–239, title VI, § 6025, Dec. 19, 1989, 103 Stat. 2167, provided that: ''Notwithstanding the requirement that the responsibility for organization and conduct of the medical staff of an institution be assigned only to a doctor of medicine or osteopathy in order for the institution to participate as a hospital under the medicare program, an institution that has a doctor of dental surgery or of dental medicine serving as its medical director shall be considered to meet such requirement if the laws of the State in which the institution is located permit a doctor of dental surgery or of dental medicine to serve as the medical staff director of a hospital.''

RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS

Pub. L. 101–239, title VI, § 6205(a)(1)(A), Dec. 19, 1989, 103 Stat. 2243, provided that: ''The reasonable costs incurred by a hospital in training students of a hospital-based nursing school shall be allowable as reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital.''

[Pub. L. 101–239, title VI, § 6205(a)(2), Dec. 19, 1989, 103 Stat. 2243, provided that: ''Paragraph (1)(A) [set out above] shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 19, 1989] and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A) [set out as a note under section 1395ww of this title].'']

DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION

Pub. L. 101–239, title VI, § 6213(e), Dec. 19, 1989, 103 Stat. 2251, directed Secretary of Health and Human Services, not later than 60 days after Dec. 19, 1989, in consultation with the Director of the Office of Rural Health Policy, to disseminate to health care facilities and to the chief executive officer, chief health officer, and chief human services officer of each State, applications and other necessary information to enable such a facility to apply for designation as a rural health clinic for the purposes of this subchapter and subchapter XIX of this chapter.

TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS

Pub. L. 101–239, title VI, § 6213(f), Dec. 19, 1989, 103 Stat. 2251, provided that: ''The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2) of the Social Security Act [42 U.S.C. 1395x(aa)(2)] if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility.''

CONTINUED USE OF HOME HEALTH WAGE INDEX IN EFFECT PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991

Pub. L. 101–239, title VI, § 6222, Dec. 19, 1989, 103 Stat. 2256, provided that: ''Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)(iii)], the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] with respect to services furnished by home health agencies, continue to utilize the wage index that was in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991.''

PAYMENT FOR MEDICAL ESCORT OR MEDICAL ATTENDANT ON COMMERCIAL AIRLINER ALLOWED

Pub. L. 100–647, title VIII, § 8427, Nov. 10, 1988, 102 Stat. 3803, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall provide that in cases where (as of the date of the enactment of this Act [Nov. 10, 1988]) transportation on a commercial airliner is covered under section 1861(s)(7) of the Social Security Act [42 U.S.C. 1395x(s)(7)], the Secretary shall also provide for payment for medically necessary services of a medical escort or medical attendant.

''(b) EFFECTIVE PERIOD.—Subsection (a) shall apply to payment for services furnished during the 5-year period beginning on July 1, 1989.''

SKILLED NURSING FACILITY; ACCESS AND VISITATION RIGHTS

Pub. L. 100–360, title IV, § 411(*l*)(2)(E), July 1, 1988, 102 Stat. 802, provided that: ''Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1819(c) of such Act [see Effective Date note set out under section 1395i–3 of this title], section 1861(j) of the Social Security Act [42 U.S.C. 1395x(j)] is deemed to include the requirement described in section 1819(c)(3)(A) of such Act [42 U.S.C. 1395i–3(c)(3)(A)] (as added by section 4201(a)(3) of OBRA).''

MORATORIUM ON PRIOR AUTHORIZATION FOR HOME HEALTH AND POST-HOSPITAL EXTENDED CARE SERVICES

Pub. L. 100–203, title IV, § 4039(e), Dec. 22, 1987, 101 Stat. 1330–82, provided that: ''The Secretary of Health and Human Services shall not implement any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under part A or B of title XVIII of the Social Security Act [42 U.S.C. 1395c

et seq., 1395j et seq.] at any time prior to six months after the date on which the Congress receives the report required under section 9305(k)(4) of the Omnibus Budget Reconciliation Act of 1986 [section 9305(k)(4) of Pub. L. 99–509, set out below].''

DELAY IN PUBLISHING REGULATIONS WITH RESPECT TO DEEMING STATUS OF ENTITIES

Pub. L. 100–203, title IV, § 4039(f), Dec. 22, 1987, 101 Stat. 1330–82, provided that: ''The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall not deem any entity to be a provider of services (as defined in section 1861(u) of the Social Security Act [42 U.S.C. 1395x(u)]) for purposes of title XVIII of such Act [42 U.S.C. 1395 et seq.]—

''(1) on any date prior to 6 months after the date on which the Secretary has published a proposed rule with respect to the deeming of the entity, and

''(2) until the Secretary publishes a final rule with respect to the deeming of the entity.''

DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT

Pub. L. 99–509, title IX, § 9305(h), Oct. 21, 1986, 100 Stat. 1993, directed Secretary of Health and Human Services to develop a uniform needs assessment instrument that could be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating individual's need for post-hospital extended care services, home health services, and long-term care services of health-related or supportive nature, and further provided for creation of advisory panel to assist Secretary and for a report to Congress not later than Jan. 1, 1989.

PRIOR AND CONCURRENT AUTHORIZATION DEMONSTRATION PROJECT

Pub. L. 99–509, title IX, § 9305(k), Oct. 21, 1986, 100 Stat. 1994, directed Secretary of Health and Human Services to conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of this subchapter, which was to include at least four projects and was to be initiated by not later than Jan. 1, 1987, under which the Secretary was to monitor the acceptance of individuals entitled to benefits under this subchapter by providers to ensure that the placement of such individuals was not delayed until the results of prior and concurrent review were known, and further directed Secretary to evaluate the demonstration program and report to Congress on such evaluation no later than Feb. 1, 1989.

CONSIDERATIONS IN ESTABLISHING LIMITS ON PAYMENT FOR HOME HEALTH SERVICES

Pub. L. 99–509, title IX, § 9315(b), Oct. 21, 1986, 100 Stat. 2006, provided that: ''In establishing limitations under section 1861(v)(1)(L) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)] on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

''(1) base such limitations on the most recent data available, which data may be for cost reporting periods beginning no earlier than October 1, 1983; and

''(2) take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements effected before, on, or after July 1, 1986.''

COMPTROLLER GENERAL STUDY AND REPORT ON COST LIMITS FOR HOME HEALTH SERVICES

Pub. L. 99–509, title IX, § 9315(c), Oct. 21, 1986, 100 Stat. 2006, directed Comptroller General to study and report to Congress, not later than Feb. 1, 1988, on appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under subsec. (v)(1)(L) of this section on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and appropriateness of the percentage limits so established.

REDUCTION IN PAYMENT TO AVOID DUPLICATE PAYMENT FOR SERVICES OF PHYSICIAN ASSISTANTS

Pub. L. 99–509, title IX, § 9338(d), Oct. 21, 1986, 100 Stat. 2035, directed Secretary of Health and Human Services to reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under this subchapter to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1395x(s)(2)(K) of this title, prior to repeal by Pub. L. 101–508, title IV, § 4002(f), Nov. 5, 1990, 104 Stat. 1388–36, effective as if included in the enactment of Pub. L. 99–509.

STUDY AND REPORT ON PAYMENTS FOR PHYSICIAN ASSISTANTS

Pub. L. 99–509, title IX, § 9338(e), Oct. 21, 1986, 100 Stat. 2035, directed Secretary to report to Congress, by Apr. 1, 1988, concerning adjustments to amount of payment made, under part B for services described in subsec. (s)(2)(K) of this section, to ensure that amount of such payments reflects approximate cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

COST LIMITS FOR ROUTINE SERVICES FOR URBAN AND RURAL HOSPITAL-BASED SKILLED NURSING FACILITIES; COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1982, AND PRIOR TO JULY 1, 1984

Pub. L. 98–369, div. B, title III, § 2319(d), July 18, 1984, 98 Stat. 1083, provided that: ''Notwithstanding limits on the cost of skilled nursing facilities which may have been issued under section 1861(v) of the Social Security Act [42 U.S.C. 1395x(v)] prior to the date of the enactment of this Act [July 18, 1984], in the case of cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, the cost limits for routine services for urban and rural hospital-based skilled nursing facilities shall be 112 percent of the mean of the respective routine costs for urban and rural hospital-based skilled nursing facilities.''

STUDY AND REPORT RELATING TO REQUIREMENTS THAT CORE SERVICES BE FURNISHED DIRECTLY BY HOSPICES

Pub. L. 98–369, div. B, title III, § 2343(d), July 18, 1984, 98 Stat. 1095, directed Secretary of Health and Human Services to conduct a study of necessity and appropriateness of requirements that certain ''core'' services be furnished directly by a hospice, as required under subsec. (dd)(2)(A)(ii)(I) of this section and report results of such study to Congress with the report required under section 122(i)(1) [122(j)(1)] of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), set out as a note under section 1395f of this title.

REPORT ON EFFECT OF 1982 AMENDMENT ON HOSPITAL-BASED SKILLED NURSING FACILITIES

Pub. L. 98–21, title VI, § 605(b), Apr. 20, 1983, 97 Stat. 169, directed Secretary of Health and Human Services, prior to Dec. 31, 1983, to complete a study and report to Congress with respect to (1) effect which implementation of section 102 of the Tax Equity and Fiscal Responsibility Act of 1982, amending this section, would have on hospital-based skilled nursing facilities, given the differences (if any) in patient populations served by such facilities and by community-based skilled nursing facilities and (2) impact on skilled nursing facilities of hospital prospective payment systems, and recommendations concerning payment of skilled nursing facilities.

Pub. L. 98–369, div. B, title III, § 2319(e), July 18, 1984, 98 Stat. 1083, directed Secretary of Health and Human Services to submit to Congress, prior to Dec. 1, 1984, the

report required under section 605(b) of the Social Security Amendments of 1983 (Pub. L. 87–21), set out above.

ELIMINATION OF PRIVATE ROOM SUBSIDY

Pub. L. 97–248, title I, § 111, Sept. 3, 1982, 96 Stat. 340, provided that:

''(a) The Secretary of Health and Human Services shall, pursuant to section 1861(v)(2) of the Social Security Act [42 U.S.C. 1395x(v)(2)], not allow as a reasonable cost the estimated amount by which the costs incurred by a hospital or skilled nursing facility for nonmedically necessary private accommodations for medicare beneficiaries exceeds the costs which would have been incurred by such hospital or facility for semiprivate accommodations.

''(b) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) as may be necessary to implement subsection (a) by October 1, 1982. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983.''

REGULATIONS REGARDING ACCESS TO BOOKS AND RECORDS

Pub. L. 96–499, title IX, § 952(b), as added by Pub. L. 97–248, title I, § 127(2), Sept. 3, 1982, 96 Stat. 366, provided that: ''Unless the Secretary of Health and Human Services first publishes final regulations prescribing the criteria and procedures described in the last sentence of section 1861(v)(1)(I) of the Social Security Act [42 U.S.C. 1395x(v)(1)(I)] by January 1, 1983, after providing a period of not less than 60 days for public comment on proposed regulations, the amendment made by subsection (a) [amending this section] shall only apply to books, documents, and records relating to services furnished (pursuant to contract or subcontract) on or after the date on which final regulations of the Secretary are first published.''

COMPLIANCE WITH THE LIFE SAFETY CODE OR STATE FIRE AND SAFETY CODE

Pub. L. 96–499, title IX, § 915(b), Dec. 5, 1980, 94 Stat. 2623, provided that: ''Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [42 U.S.C. 1395x(j)(13)] on the day before the date of the enactment of this Act [Dec. 5, 1980] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967, or 23d edition, 1973), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII or XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.]) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.''

Pub. L. 94–182, title I, § 106(c), Dec. 31, 1975, 89 Stat. 1052, provided that: ''Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [42 U.S.C. 1395x(j)(13)] on the day preceding the first day referred to in subsection (b) [enacting provisions set out as a note under this section] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII and XIX of such Act) [42 U.S.C. 1395 et seq., 1396 et seq.] to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.''

PRIVATE, NONPROFIT HEALTH CARE CLINICS QUALIFYING, AS OF JULY 1, 1977, AS RURAL HEALTH CLINICS

Pub. L. 95–210, § 1(e), Dec. 13, 1977, 91 Stat. 1487, provided that: ''Any private, nonprofit health care clinic that—

''(1) on July 1, 1977, was operating and located in an area which on that date (A) was not an urbanized area (as defined by the Bureau of the Census) and (B) had a supply of physicians insufficient to meet the needs of the area (as determined by the Secretary), and

''(2) meets the definition of a rural health clinic under section 1861(aa)(2) [42 U.S.C. 1395x(aa)(2)] or section 1905(*l*) of the Social Security Act [42 U.S.C. 1396d(*l*)], except for clause (i) of section 1861(aa)(2) [42 U.S.C. 1395x(aa)(2)],

shall be considered, for the purposes of title XVIII or XIX, respectively, of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.], as satisfying the definition of a rural health clinic under such section.''

PROMULGATION OF REGULATIONS DEFINING COSTS CHARGEABLE TO PERSONAL FUNDS OF PATIENTS IN SKILLED NURSING FACILITIES; DATE OF ISSUANCE

Pub. L. 95–142, § 21(b), Oct. 25, 1977, 91 Stat. 1207, provided that: ''The Secretary of Health, Education, and Welfare [now Health and Human Services] shall, by regulation, define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under the provisions of title XVIII [42 U.S.C. 1395 et seq.], or under a State plan approved under the provisions of title XIX [42 U.S.C. 1396 et seq.], of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for extended care services as determined under the provisions of title XVIII, or for skilled nursing and intermediate care facility services as determined under the provisions of title XIX, of such Act.''

[Pub. L. 95–142, § 21(c)(2), Oct. 25, 1977, 91 Stat. 1208, provided that: ''The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (b) [set out above] within ninety days after the date of enactment of this Act [Oct. 25, 1977].'']

HOME HEALTH SERVICES; GRANTS FOR ESTABLISHMENT, OPERATION, STAFFING, ETC., OF PUBLIC AND NONPROFIT PRIVATE AGENCIES AND ENTITIES; PROCEDURES; PAYMENTS; AUTHORIZATION OF APPROPRIATIONS

Pub. L. 94–63, title VI, § 602, July 29, 1975, 89 Stat. 346, as amended by Pub. L. 94–460, title III, § 302, Oct. 8, 1976, 90 Stat. 1960; Pub. L. 95–83, title III, § 310, Aug. 1, 1977, 91 Stat. 397, which provided for a program of home health services and of training of professional and paraprofessional personnel, was repealed by Pub. L. 95–626, title II, § 207(b), Nov. 10, 1978, 92 Stat. 3586, effective Oct. 1, 1978.

PAYMENT FOR SERVICE OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL FOR ACCOUNTING PERIODS BEGINNING AFTER JUNE 30, 1975, AND PRIOR TO OCTOBER 1, 1978; STUDIES, REPORTS, ETC.; EFFECTIVE DATES

Pub. L. 93–233, § 15(a)(1), (b)–(d), Dec. 31, 1973, 87 Stat. 965, as amended by Pub. L. 93–368, § 7, Aug. 7, 1974, 88 Stat. 422; Pub. L. 94–368, § 1, July 16, 1976, 90 Stat. 997; Pub. L. 95–292, § 7, June 13, 1978, 92 Stat. 316, provided that for the cost accounting periods beginning after June 30, 1975, and prior to October 1, 1978, subsec. (b) of this section will be administered as if paragraph (7) of subsec. (b) read as follows: ''(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title [42 U.S.C. 1395 et seq.] for reasonable costs of such services, and (B) all physi-

cians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title [42 U.S.C. 1395 et seq.]'', provided for studies with respect to methods of reimbursement for physicians' services under subchapters XVIII and XIX of this chapter in hospitals which have a teaching program and a determination as to how and to what extent such funds are utilized, and provided that a final report be submitted to the Secretary of Health, Education, and Welfare, the Committee on Finance of the Senate, and the Committee on Ways and Means of the House of Representatives not later than Mar. 1, 1976.

PHYSICAL THERAPY SERVICES REQUIREMENTS; EFFECTIVE DATE POSTPONEMENT

Pub. L. 93–233, §17(a), Dec. 31, 1973, 87 Stat. 967, provided that: ''In the administration of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the amount payable thereunder with respect to physical therapy and other services referred to in section 1861(v)(5)(A) of such Act [42 U.S.C. 1395x(v)(5)(A)] (as added by section 151(c) [251(c)] of the Social Security Amendments of 1972) shall be determined (for the period with respect to which the amendment made by such section 151(c) [251(c)] would, except for the provisions of this section, be applicable) in like manner as if the 'December 31, 1972', which appears in such subsection (d)(3) of such section 151 [251(d)(3), set out as Effective Date of 1972 Amendment note above], read 'the month in which there are promulgated, by the Secretary of Health, Education, and Welfare, final regulations implementing the provisions of section 1861(v)(5) of the Social Security Act [42 U.S.C. 1395x(v)(5)]'.''

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

Pub. L. 92–603, title II, §245(a)–(c), Oct. 30, 1972, 86 Stat. 1423, provided that:

''(a) The Secretary is authorized to conduct reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment described in section 1861(s)(6) of the Social Security Act [42 U.S.C. 1395x(s)(6)].

''(b) Such experiment may be conducted in one or more geographic areas, as the Secretary deems appropriate, and may, pursuant to agreements with suppliers, provide for reimbursement for such equipment on a lump-sum basis whenever it is determined (in accordance with guidelines established by the Secretary) that a lump-sum payment would be more economical than the anticipated period of rental payments. Such experiments may also provide for incentives to beneficiaries (including waiver of the 20 percent coinsurance amount applicable under section 1833 of the Social Security Act [42 U.S.C. 1395*l*]) to purchase used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for new equipment.

''(c) The Secretary is authorized, at such time as he deems appropriate, to implement on a nationwide basis any such reimbursement procedures which he finds to be workable, desirable and economical and which are consistent with the purposes of this section.''

Executive Documents

RESPECTING THE RIGHTS OF HOSPITAL PATIENTS TO RECEIVE VISITORS AND TO DESIGNATE SURROGATE DECISION MAKERS FOR MEDICAL EMERGENCIES

Memorandum of President of the United States, Apr. 15, 2010, 75 F.R. 20511, provided:

Memorandum for the Secretary of Health and Human Services

There are few moments in our lives that call for greater compassion and companionship than when a loved one is admitted to the hospital. In these hours of need and moments of pain and anxiety, all of us would hope to have a hand to hold, a shoulder on which to lean—a loved one to be there for us, as we would be there for them.

Yet every day, all across America, patients are denied the kindnesses and caring of a loved one at their sides—whether in a sudden medical emergency or a prolonged hospital stay. Often, a widow or widower with no children is denied the support and comfort of a good friend. Members of religious orders are sometimes unable to choose someone other than an immediate family member to visit them and make medical decisions on their behalf. Also uniquely affected are gay and lesbian Americans who are often barred from the bedsides of the partners with whom they may have spent decades of their lives—unable to be there for the person they love, and unable to act as a legal surrogate if their partner is incapacitated.

For all of these Americans, the failure to have their wishes respected concerning who may visit them or make medical decisions on their behalf has real consequences. It means that doctors and nurses do not always have the best information about patients' medications and medical histories and that friends and certain family members are unable to serve as intermediaries to help communicate patients' needs. It means that a stressful and at times terrifying experience for patients is senselessly compounded by indignity and unfairness. And it means that all too often, people are made to suffer or even to pass away alone, denied the comfort of companionship in their final moments while a loved one is left worrying and pacing down the hall.

Many States have taken steps to try to put an end to these problems. North Carolina recently amended its Patients' Bill of Rights to give each patient ''the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient''—a right that applies in every hospital in the State. Delaware, Nebraska, and Minnesota have adopted similar laws.

My Administration can expand on these important steps to ensure that patients can receive compassionate care and equal treatment during their hospital stays. By this memorandum, I request that you take the following steps:

1. Initiate appropriate rulemaking, pursuant to your authority under 42 U.S.C. 1395x and other relevant provisions of law, to ensure that hospitals that participate in Medicare or Medicaid respect the rights of patients to designate visitors. It should be made clear that designated visitors, including individuals designated by legally valid advance directives (such as durable powers of attorney and health care proxies), should enjoy visitation privileges that are no more restrictive than those that immediate family members enjoy. You should also provide that participating hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. The rulemaking should take into account the need for hospitals to restrict visitation in medically appropriate circumstances as well as the clinical decisions that medical professionals make about a patient's care or treatment.

2. Ensure that all hospitals participating in Medicare or Medicaid are in full compliance with regulations, codified at 42 CFR 482.13 and 42 CFR 489.102(a), promulgated to guarantee that all patients' advance directives, such as durable powers of attorney and health care proxies, are respected, and that patients' representatives otherwise have the right to make informed decisions regarding patients' care. Additionally, I request that you issue new guidelines, pursuant to your authority under 42 U.S.C. 1395cc and other relevant provisions of law, and provide technical assistance on how hospitals participating in Medicare or Medicaid can best comply with the regulations and take any additional appropriate measures to fully enforce the regulations.

3. Provide additional recommendations to me, within 180 days of the date of this memorandum, on actions the Department of Health and Human Services can take to address hospital visitation, medical decisionmaking, or other health care issues that affect LGBT patients and their families.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

§ 1395y. Exclusions from coverage and medicare as secondary payer

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,[1]

(E) in the case of research conducted pursuant to section 1320b–12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(*oo*) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w–3a(c)(6)(C) of this title for which payment is made under part B that is furnished in a competitive area under section 1395w–3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B,

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1395x(s)(2)(AA) of this title,

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), which are performed more frequently than is covered under such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear

[1] See References in Text note below.

described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of subchapter XI) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w–4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.];

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w–3(a) of this title) by an entity other than an entity with which the Secretary has entered into a contract under section 1395w–3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w–4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an

accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title;

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title. In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (*l*) that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term ''group health plan'' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term ''large group health plan'' has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title during the 12-month pe-

riod which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[2] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting ''18-month'' for ''12-month'' each place it appears. Effective for items and services furnished on or after August 5, 1997,[2] (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting ''30-month'' for ''12-month'' each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined

An individual has ''current employment status'' with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term ''employer'' includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made[3] or can reasonably be expected to be made[3] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term ''primary plan'' means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii)[4] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust

[2] So in original. The comma probably should not appear.

[3] So in original. Probably should be ''made,''.

[4] So in original. Probably should be''subparagraph (A)''.

Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and

payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a ''statement of reimbursement amount'') on payments for claims under this subchapter relating to a potential settlement, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term ''protected period'' means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term ''website'' includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination[6]

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(*l*)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(*l*)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

[5] So in original. Probably should be ''subparagraph (A),''.

[6] So in original. Probably should be followed by a period.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an ''employee'') who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(*l*)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

(I) a primary plan to the program under this subchapter; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term ''claimant'' includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term ''applicable plan'' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020, from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwith-

standing any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this subchapter on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year—

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this subchapter

achieved by the Secretary implementing each such threshold.

(c) Drug products

No payment may be made under part B for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) Items or services provided for emergency medical conditions

For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a–7, 1320a–7a, 1320c–5, 1320c–9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or 1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with quality improvement organizations

(1) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with quality improvement organizations pursuant to part B of subchapter XI of this chapter.

(2) In addition to any funds otherwise available, there are appropriated to the Secretary, out of any monies in the Treasury not otherwise obligated, $200,000,000, to remain available until expended, for purposes of requiring multiple organizations described in paragraph (1) to provide to skilled nursing facilities (as defined in section 1935i–3(a) of this title), infection control and vaccination uptake support relating to the prevention or mitigation of COVID–19, as determined appropriate by the Secretary.

(h) Waiver of electronic form requirement

(1) The Secretary—

(A) shall waive the application of subsection (a)(22) in cases in which—

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term ''small provider of services or supplier'' means—

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1395ww(e)(6)(E) of this title with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j) Nonvoting members and experts

(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5 by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k) Dental benefits under group health plans

(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v))[7] providing supplemental or secondary coverage to individuals also entitled to services under this subchapter shall not require a medicare claims determination under this subchapter for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this subchapter in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this subchapter pursuant to actions taken by the Secretary.

***(l)* National and local coverage determination process**

(1) Factors and evidence used in making national coverage determinations

The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of title 21.

(2) Timeframe for decisions on requests for national coverage determinations

In the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) Process for public comment in national coverage determinations

(A) Period for proposed decision

Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-day period for public comment

Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-day period for final decision

Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

[7] So in original. Probably should be ''(b)(1)(A)(v))''.

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) Consultation with outside experts in certain national coverage determinations

With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) Local coverage determination process

(A) Plan to promote consistency of coverage determinations

The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) Consultation

The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) Dissemination of information

The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(D) Local coverage determinations

The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

(i) Such determination in its entirety.

(ii) Where and when the proposed determination was first made public.

(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

(v) An explanation of the rationale that supports such determination.

(6) National and local coverage determination defined

For purposes of this subsection—

(A) National coverage determination

The term ''national coverage determination'' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter.

(B) Local coverage determination

The term ''local coverage determination'' has the meaning given that in section 1395ff(f)(2)(B) of this title.

(m) Coverage of routine costs associated with certain clinical trials of category A devices

(1) In general

In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category A clinical trial

For purposes of paragraph (1), a ''category A clinical trial'' means a trial of a medical device if—

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

(n) Requirement of a surety bond for certain providers of services and suppliers

(1) In general

The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

(2) Provider of services or supplier described

A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1395m(a)(16)(B) and 1395x(*o*)(7)(C) of this title.

***(o)* Suspension of payments pending investigation of credible allegations of fraud**

(1) In general

The Secretary may suspend payments to a provider of services or supplier under this sub-

chapter pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

(2) Consultation

The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) Promulgation of regulations

The Secretary shall promulgate regulations to carry out this subsection, section 1395w–112(b)(7) of this section (including as applied pursuant to section 1395w–27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title.

(4) Credible allegation of fraud

In carrying out this subsection, section 1395w–112(b)(7) of this title (including as applied pursuant to section 1395w–27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.

(Aug. 14, 1935, ch. 531, title XVIII, §1862, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 325; amended Pub. L. 90–248, title I, §§127(b), 128, Jan. 2, 1968, 81 Stat. 846, 847; Pub. L. 92–603, title II, §§210, 211(c)(1), 229(a), 256(c), Oct. 30, 1972, 86 Stat. 1382, 1384, 1408, 1447; Pub. L. 93–233, §18(k)(3), Dec. 31, 1973, 87 Stat. 970; Pub. L. 93–480, §4(a), Oct. 26, 1974, 88 Stat. 1454; Pub. L. 94–182, title I, §103, Dec. 31, 1975, 89 Stat. 1051; Pub. L. 95–142, §§7(a), 13(a), (b)(1), (2), Oct. 25, 1977, 91 Stat. 1192, 1197, 1198; Pub. L. 95–210, §1(f), Dec. 13, 1977, 91 Stat. 1487; Pub. L. 96–272, title III, §308(a), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, §§913(b), 936(c), 939(a), 953, Dec. 5, 1980, 94 Stat. 2620, 2640, 2647; Pub. L. 96–611, §1(a)(3), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§2103(a)(1), 2146(a), 2152(a), Aug. 13, 1981, 95 Stat. 787, 800, 802; Pub. L. 97–248, title I, §§116(b), 122(f), (g)(1), 128(a)(2)–(4), 142, 148(a), Sept. 3, 1982, 96 Stat. 353, 362, 366, 381, 394; Pub. L. 97–448, title III, §309(b)(10), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§601(f), 602(e), Apr. 20, 1983, 97 Stat. 162, 163; Pub. L. 98–369, div. B, title III, §§2301(a), 2304(c), 2313(c), 2344(a)–(c), 2354(b)(30), (31), July 18, 1984, 98 Stat. 1063, 1068, 1078, 1095, 1101, 1102; Pub. L. 99–272, title IX, §§9201(a), 9307(a), 9401(c)(1), Apr. 7, 1986, 100 Stat. 170, 193, 199; Pub. L. 99–509, title IX, §§9316(b), 9319(a), (b), 9320(h)(1), 9343(c)(1), Oct. 21, 1986, 100 Stat. 2007, 2010, 2011, 2016, 2040; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–93, §§8(c)(1), (3), 10, Aug. 18, 1987, 101 Stat. 692, 693, 696; Pub. L. 100–203, title IV, §§4009(j)(6)(C), 4034(a), 4036(a)(1), 4039(c)(1), 4072(c), 4085(i)(15), (16), Dec. 22, 1987, 101 Stat. 1330–59, 1330–77, 1330–79, 1330–82, 1330–117, 1330–133; Pub. L. 100–360, title II, §§202(d), 204(d)(2), 205(e)(1), title IV, §411(f)(4)(D)(i), (i)(4)(D), July 1, 1988, 102 Stat. 715, 729, 731, 778, 790; Pub. L. 100–485, title VI, §608(d)(7), (24)(C), Oct. 13, 1988, 102 Stat. 2415, 2421; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xi), 6103(b)(3)(B), 6115(b), 6202(a)(2)(A), (b)(1), (e)(1), 6411(d)(2), Dec. 19, 1989, 103 Stat. 2154, 2199, 2219, 2228, 2229, 2234, 2271; Pub. L. 101–508, title IV, §§4107(b), 4153(b)(2)(B), 4157(c)(1), 4161(a)(3)(C), 4163(d)(2), 4203(a)(1), (b), (c)(1), 4204(g)(1), Nov. 5, 1990, 104 Stat. 1388–62, 1388–84, 1388–89, 1388–94, 1388–100, 1388–107, 1388–112; Pub. L. 103–66, title XIII, §§13561(a)(1), (b)–(d)(1), (e)(1), 13581(b)(1), Aug. 10, 1993, 107 Stat. 593, 594, 611; Pub. L. 103–432, title I, §§145(c)(1), 147(e)(6), 151(a)(1)(A), (C), (2)(A), (b)(3)(A), (B), (c)(1), (4)–(6), (9)(B), 156(a)(2)(D), 157(b)(7), Oct. 31, 1994, 108 Stat. 4427, 4430, 4432–4436, 4441, 4442; Pub. L. 104–224, §1, Oct. 2, 1996, 110 Stat. 3031; Pub. L. 104–226, §1(b)(1), Oct. 2, 1996, 110 Stat. 3033; Pub. L. 105–12, §9(a)(1), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4022(b)(1)(B), 4102(c), 4103(c), 4104(c)(3), 4201(c)(1), 4319(b), 4432(b)(1), 4507(a)(2)(B), 4511(a)(2)(C), 4541(b), 4603(c)(2)(C), 4614(a), 4631(a)(1), (b), (c)(1), 4632(a), 4633(a), (b), Aug. 5, 1997, 111 Stat. 354, 361, 362, 365, 373, 394, 420, 441, 442, 456, 471, 474, 486, 487; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §§305(b), 321(k)(10)], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, 1501A–367; Pub. L. 106–554, §1(a)(6) [title I, §102(c), title III, §313(a), title IV, §432(b)(1), title V, §522(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, 2763A–499, 2763A–526, 2763A–546; Pub. L. 107–105, §3(a), Dec. 27, 2001, 115 Stat. 1006; Pub. L. 108–173, title III, §§301(a)–(c), 303(i)(3)(B), title VI, §§611(d)(1), 612(c), 613(c), title VII, §731(a)(1), (b)(1), title IX, §§900(e)(1)(J), 944(a)(1), 948(a), 950(a), Dec. 8, 2003, 117 Stat. 2221, 2222, 2254, 2304–2306, 2349, 2351, 2372, 2422, 2425, 2426; Pub. L. 109–171, title V, §5112(d), Feb. 8, 2006, 120 Stat. 44; Pub. L. 110–173, title I, §111(a), Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, §§101(a)(3), (b)(3), (4), 135(a)(2)(A), 143(b)(7), 152(b)(1)(D), 153(b)(2), July 15, 2008, 122 Stat. 2497, 2498, 2535, 2543, 2552, 2555; Pub. L. 111–148, title I, §1104(d), title IV, §4103(d), title VI, §6402(g)(3), (h)(1), Mar. 23, 2010, 124 Stat. 153, 556, 759, 760; Pub. L. 112–40, title II, §261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–242, title II, §§201, 202(a), 203–205(a), Jan. 10, 2013, 126 Stat. 2375, 2378, 2380, 2381; Pub. L. 113–188, title IX, §902(d), Nov. 26, 2014, 128 Stat. 2022; Pub. L. 114–10, title V, §516(a), Apr. 16, 2015, 129 Stat. 175; Pub. L. 114–255, div. A, title IV, §4009(a), Dec. 13, 2016, 130 Stat. 1185; Pub. L. 115–271, title II, §2008(c), (d), title IV, §4002, Oct. 24, 2018, 132 Stat. 3931, 3959; Pub. L. 116–215, div. B, title III, §1301, Dec. 11, 2020, 134 Stat. 1045; Pub. L. 117–2, title IX, §9401, Mar. 11, 2021, 135 Stat. 127.)

Editorial Notes

REFERENCES IN TEXT

Section 1395ww(e)(6) of this title, referred to in subsec. (a)(1)(D), was repealed by Pub. L. 105–33, title IV, §4022(b)(1)(A)(i), Aug. 5, 1997, 111 Stat. 354.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (a)(16), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b), is classified generally to Title 26, Internal Revenue Code.

Section 107(c)(3) of the Drug Amendments of 1962, referred to in subsec. (c)(1)(A), is section 107(c)(3) of Pub. L. 87–781, title I, Oct. 10, 1962, 76 Stat. 788, which is set

out as an Effective Date of 1962 Amendment note under section 321 of Title 21, Food and Drugs.

CODIFICATION

Section 1314(i) of this title, which was transferred and redesignated as subsec. (j) of this section by Pub. L. 108–173, was based on act Aug. 14, 1935, ch. 531, title XI, § 1114(i), as added Pub. L. 106–554, § 1(a)(6) [title V, § 522(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–546.

Amendments by section 301(a) to (c) of Pub. L. 108–173 were executed to this section as it read on the date of enactment of Pub. L. 108–173 to reflect the probable intent of Congress, notwithstanding section 301(d) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note below, which provided that the amendments by section 301(a) of Pub. L. 108–173 be effective as if included in the enactment of title III of Pub. L. 98–369 and that the amendments by section 301(b), (c) of Pub. L. 108–173 be effective as if included in the enactment of section 953 of Pub. L. 96–499. The amendments by section 301(a) are incapable of being executed to this section as it read on the effective date of title III of Pub. L. 98–369, and the amendments by section 301(b), (c) are incapable of being executed to this section as it read on the effective date of section 953 of Pub. L. 96–499. See 2003 Amendment notes below.

AMENDMENTS

2021—Subsec. (g). Pub. L. 117–2 designated existing provisions as par. (1) and added par. (2).

2020—Subsec. (b)(8)(G). Pub. L. 116–215 inserted clause (i) designation and heading and added clause (ii).

2018—Subsec. (b)(7)(A)(i). Pub. L. 115–271, § 4002, amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: ''secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and''.

Subsec. (*o*)(3). Pub. L. 115–271, § 2008(c), inserted '', section 1395w–112(b)(7) of this section (including as applied pursuant to section 1395w–27(f)(3)(D) of this title),'' after ''this subsection''.

Subsec. (*o*)(4). Pub. L. 115–271, § 2008(d), added par. (4).

2016—Subsec. (*l*)(5)(D). Pub. L. 114–255 added subpar. (D).

2015—Subsec. (b)(5)(E). Pub. L. 114–10 added subpar. (E).

2014—Subsec. (b)(9)(B)(i). Pub. L. 113–188 substituted ''for 2014, the Secretary shall'' for ''for a year, the Secretary shall''.

2013—Subsec. (b)(2)(B)(ii). Pub. L. 112–242, § 202(a)(1), substituted ''Subject to paragraph (9), a primary plan'' for ''A primary plan''.

Subsec. (b)(2)(B)(iii). Pub. L. 112–242, § 205(a), inserted at end ''An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.''

Subsec. (b)(2)(B)(vii), (viii). Pub. L. 112–242, § 201, added cls. (vii) and (viii).

Subsec. (b)(8)(B). Pub. L. 112–242, § 204, inserted concluding provisions.

Subsec. (b)(8)(E)(i). Pub. L. 112–242, § 203(1), substituted ''may be subject to a civil money penalty of up to $1,000'' for ''shall be subject to a civil money penalty of $1,000''.

Subsec. (b)(8)(I). Pub. L. 112–242, § 203(2), added subpar. (I).

Subsec. (b)(9). Pub. L. 112–242, § 202(a)(2), added par. (9).

2011—Subsecs. (a)(15)(A), (g). Pub. L. 112–40 substituted ''quality improvement'' for ''utilization and quality control peer review''.

2010—Subsec. (a)(1)(P). Pub. L. 111–148, § 4103(d)(1), added subpar. (P).

Subsec. (a)(7). Pub. L. 111–148, § 4103(d)(2), substituted ''(K), or (P)'' for ''or (K)''.

Subsec. (a)(25). Pub. L. 111–148, § 1104(d), added par. (25).

Subsec. (n). Pub. L. 111–148, § 6402(g)(3), added subsec. (n).

Subsec. (*o*). Pub. L. 111–148, § 6402(h)(1), added subsec. (*o*).

2008—Subsec. (a)(1)(A). Pub. L. 110–275, § 101(a)(3), inserted ''or additional preventive services (as described in section 1395x(ddd)(1) of this title)'' after ''succeeding subparagraph''.

Subsec. (a)(1)(K). Pub. L. 110–275, § 101(b)(3), (4), substituted ''more'' for ''not later'' and ''1 year'' for ''6 months''.

Subsec. (a)(1)(O). Pub. L. 110–275, § 152(b)(1)(D), added subpar. (O).

Subsec. (a)(20). Pub. L. 110–275, § 143(b)(7), substituted ''outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services'' for ''outpatient occupational therapy services or outpatient physical therapy services'' and ''subsection (g) or (*ll*)(2) of section 1395x'' for ''section 1395x(g)''.

Subsec. (a)(23). Pub. L. 110–275, § 135(a)(2)(A), added par. (23).

Subsec. (a)(24). Pub. L. 110–275, § 153(b)(2), added par. (24).

2007—Subsec. (b)(7), (8). Pub. L. 110–173 added pars. (7) and (8).

2006—Subsec. (a)(1)(N). Pub. L. 109–171 added subpar. (N).

2003—Subsec. (a). Pub. L. 108–173, § 948(a)(2)(A), struck out ''established under section 1314(f) of this title'' after ''meetings of advisory committees'' in concluding provisions.

Pub. L. 108–173, § 731(a)(1)(A), inserted ''consistent with subsection (*l*)'' after ''the Secretary shall ensure'' in concluding provisions.

Subsec. (a)(1)(J). Pub. L. 108–173, § 303(i)(3)(B), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 108–173, § 611(d)(1)(A), added subpar. (K).

Subsec. (a)(1)(L). Pub. L. 108–173, § 612(c), added subpar. (L).

Subsec. (a)(1)(M). Pub. L. 108–173, § 613(c), added subpar. (M).

Subsec. (a)(7). Pub. L. 108–173, § 611(d)(1)(B), substituted ''(H), or (K)'' for ''or (H)''.

Subsec. (b)(1)(A). Pub. L. 108–173, § 301(c)(1), realigned margins.

Subsec. (b)(2)(A). Pub. L. 108–173, § 301(b)(1), inserted at end of concluding provisions ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.''

Subsec. (b)(2)(A)(ii). Pub. L. 108–173, § 301(a)(1), struck out ''promptly (as determined in accordance with regulations)'' after ''be expected to be made''.

Subsec. (b)(2)(B)(i). Pub. L. 108–173, § 301(a)(2)(B), added cl. (i). Former cl. (i) redesignated (ii).

Subsec. (b)(2)(B)(ii). Pub. L. 108–173, § 301(b)(2), substituted ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.'' for ''Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has

been or could be made under such subparagraph.'' and ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received'' for ''on the date such notice or other information is received''.

Pub. L. 108–173, §301(a)(2)(A), redesignated cl. (i) as (ii). Former cl. (ii) redesignated (iii).

Subsec. (b)(2)(B)(iii). Pub. L. 108–173, §301(b)(3), substituted ''In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.'' for ''In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.''

Pub. L. 108–173, §301(a)(2)(A), redesignated cl. (ii) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (b)(2)(B)(iv) to (vi). Pub. L. 108–173, §301(a)(2)(A), redesignated cls. (iii) to (v) as (iv) to (vi), respectively.

Subsec. (b)(3)(A). Pub. L. 108–173, §301(c)(2), struck out ''such'' before ''paragraphs''.

Subsec. (b)(5)(A)(ii). Pub. L. 108–173, §900(e)(1)(J), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Subsec. (d). Pub. L. 108–173, §944(a)(1), added subsec. (d).

Subsec. (j). Pub. L. 108–173, §948(a)(1), transferred subsec. (i) of section 1314 of this title and redesignated it as subsec. (j) of this section. See Codification note above.

Subsec. (j)(1). Pub. L. 108–173, §948(a)(2)(B), in introductory provisions, struck out ''under subsection (f)'' after ''appointed'' and substituted ''subsection (a)(1)'' for ''section 1395y(a)(1) of this title''.

Subsec. (k). Pub. L. 108–173, §950(a), added subsec. (k).

Subsec. (*l*). Pub. L. 108–173, §731(a)(1)(B), added subsec. (*l*).

Subsec. (m). Pub. L. 108–173, §731(b)(1), added subsec. (m).

2001—Subsec. (a)(22). Pub. L. 107–105, §3(a)(1), added par. (22).

Subsec. (h). Pub. L. 107–105, §3(a)(2), added subsec. (h).

2000—Subsec. (a). Pub. L. 106–554, §1(a)(6) [title V, §522(b)], inserted at end ''In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees established under section 1314(f) of this title with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.''

Subsec. (a)(1)(F). Pub. L. 106–554, §1(a)(6) [title I, §102(c)], struck out ''and,'' after ''section 1395m(c)(1)(B) of this title,'' and inserted at end ''and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,''.

Subsec. (a)(3). Pub. L. 106–554, §1(a)(6) [title IV, §432(b)(1)], struck out second comma after ''section 1395x(aa)(1) of this title'' and inserted ''in the case of services for which payment may be made under section 1395qq(e) of this title,'' after ''section 1395x(aa)(3) of this title,''.

Subsec. (a)(18). Pub. L. 106–554, §1(a)(6) [title III, §313(a)], substituted ''during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period),'' for ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations),''.

1999—Subsec. (a)(7). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(10)], substituted ''subparagraph'' for ''subparagraphs''.

Subsec. (a)(21). Pub. L. 106–113, §1000(a)(6) [title III, §305(b)], inserted ''(including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section)'' after ''home health services''.

1997—Subsec. (a)(1)(D). Pub. L. 105–33, §4022(b)(1)(B), substituted ''Medicare Payment Advisory Commission'' for ''Prospective Payment Assessment Commission''.

Subsec. (a)(1)(F). Pub. L. 105–33, §4102(c), inserted ''and screening pelvic exam'' after ''screening pap smear''.

Subsec. (a)(1)(G). Pub. L. 105–33, §4103(c)(1), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 105–33, §4104(c)(3)(A), added subpar. (H).

Subsec. (a)(1)(I). Pub. L. 105–33, §4614(a), added subpar. (I).

Subsec. (a)(7). Pub. L. 105–33, §4104(c)(3)(B), substituted ''(G), or (H)'' for ''or (G)''.

Pub. L. 105–33, §4103(c)(2), substituted ''subparagraphs (B), (F), or (G) of paragraph (1)'' for ''paragraph (1)(B) or under paragraph (1)(F)''.

Subsec. (a)(14). Pub. L. 105–33, §4511(a)(2)(C), substituted ''section 1395x(s)(2)(K) of this title'' for ''section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title''.

Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' wherever appearing.

Subsec. (a)(16). Pub. L. 105–12 added par. (16).

Subsec. (a)(17). Pub. L. 105–33, §4319(b), added par. (17).

Subsec. (a)(18). Pub. L. 105–33, §4432(b)(1), added par. (18).

Subsec. (a)(19). Pub. L. 105–33, §4507(a)(2)(B), added par. (19).

Subsec. (a)(20). Pub. L. 105–33, §4541(b), added par. (20).

Subsec. (a)(21). Pub. L. 105–33, §4603(c)(2)(C), added par. (21).

Subsec. (b)(1)(B)(i). Pub. L. 105–33, §4631(a)(1)(A), substituted ''in clause (iii))'' for ''in clause (iv))''.

Subsec. (b)(1)(B)(iii), (iv). Pub. L. 105–33, §4631(a)(1)(B), (C), redesignated cl. (iv) as (iii) and struck out heading and text of former cl. (iii). Text read as follows: ''Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998.''

Subsec. (b)(1)(C). Pub. L. 105–33, §4631(b), in concluding provisions, substituted ''August 5, 1997'' for ''October 1, 1998'' and inserted at end ''Effective for items and services furnished on or after August 5, 1997, (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''

Subsec. (b)(1)(F). Pub. L. 105–33, §4633(b), added subpar. (F).

Subsec. (b)(2)(B)(ii). Pub. L. 105–33, §4633(a), substituted ''(directly, as a third-party administrator, or otherwise) to make payment'' for ''under this subsection to pay'' and inserted at end ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''

Subsec. (b)(2)(B)(v). Pub. L. 105–33, §4632(a), added cl. (v).

Subsec. (b)(5)(C)(iii). Pub. L. 105–33, §4631(c)(1), struck out heading and text of cl. (iii). Text read as follows: ''Clause (ii) shall not apply to inquiries made after September 30, 1998.''

Subsec. (i). Pub. L. 105–33, §4022(b)(1)(B), substituted ''Medicare Payment Advisory Commission'' for ''Prospective Payment Assessment Commission'' in introductory provisions.

1996—Subsec. (b)(5)(B). Pub. L. 104–226, §1(b)(1)(A), substituted ''under subparagraph (A) for purposes of carrying out this subsection'' for ''under—

''(i) subparagraph (A), and

''(ii) section 1320b–14 of this title,

for purposes of carrying out this subsection''.

Subsec. (b)(5)(C)(i). Pub. L. 104–226, §1(b)(1)(B), substituted ''disclosed under subparagraph (B)'' for ''disclosed under subparagraph (B)(i)''.

Subsec. (h). Pub. L. 104–224 struck out subsec. (h) which required Secretary to provide registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under this chapter.

1994—Subsec. (a)(1)(F). Pub. L. 103–432, §145(c)(1), substituted ''or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title'' for ''or which does not meet the standards established under section 1395m(c)(3) of this title''.

Subsec. (a)(14). Pub. L. 103–432, §156(a)(2)(D)(i), inserted ''or'' at end.

Pub. L. 103–432, §147(e)(6), substituted ''section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title'' for ''section 1395x(s)(2)(K)(i) of this title''.

Subsec. (a)(15). Pub. L. 103–432, §156(a)(2)(D)(ii), substituted period for ''; or'' at end.

Subsec. (a)(16). Pub. L. 103–432, §156(a)(2)(D)(iii), struck out par. (16) which read as follows: ''furnished in connection with a surgical procedure for which a second opinion is required under section 1320c–13(c)(2) of this title and has not been obtained.''

Subsec. (b)(1)(A)(i)(II). Pub. L. 103–432, §151(c)(1)(A), substituted ''older (and the spouse age 65 or older of any individual) who has current employment status with an employer'' for ''over (and the individual's spouse age 65 or older) who is covered under the plan by virtue of the individual's current employment status with an employer''.

Subsec. (b)(1)(A)(ii). Pub. L. 103–432, §151(c)(1)(B), substituted ''employer that has 20 or more employees'' for ''employer or employee organization that has 20 or more individuals in current employment status''.

Subsec. (b)(1)(A)(v). Pub. L. 103–432, §151(c)(9)(B), made technical amendment to directory language of Pub. L. 103–66, §13561(e)(1)(D). See 1993 Amendment note below.

Subsec. (b)(1)(C). Pub. L. 103–432, §151(c)(5), substituted ''paying benefits secondary to this subchapter when'' for ''taking into account that'' in closing provisions.

Pub. L. 103–432, §151(c)(4), substituted ''this subparagraph'' for ''clauses (i) and (ii)'' after ''February 1, 1990),'' in last sentence.

Subsec. (b)(2)(B)(i). Pub. L. 103–432, §151(b)(3)(A), (B), substituted ''Repayment required'' for ''Primary plans'' in heading and inserted at end ''If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).''

Subsec. (b)(2)(C). Pub. L. 103–432, §151(a)(1)(C), added subpar. (C).

Subsec. (b)(3)(C). Pub. L. 103–432, §157(b)(7), substituted ''group health plan or a large group health plan'' for ''group health plan'' in heading and text, struck out '', unless such incentive is also offered to all individuals who are eligible for coverage under the plan'' after ''(as defined in paragraph (2)(A))'', and substituted ''(other than subsections (a) and (b))'' for ''(other than the first sentence of subsection (a) and other than subsection (b))''.

Subsec. (b)(5)(C)(i). Pub. L. 103–432, §151(c)(6), substituted ''section 6103(*l*)(12)(E)(iii) of such Code'' for ''section 6103(*l*)(12)(D)(iii) of such Code''.

Subsec. (b)(5)(D). Pub. L. 103–432, §151(a)(1)(A), added subpar. (D).

Subsec. (b)(6). Pub. L. 103–432, §151(a)(2)(A), added par. (6).

1993—Subsec. (b)(1)(A)(i). Pub. L. 103–66, §13561(e)(1)(A), amended subcls. (I) and (II) generally. Prior to amendment, subcls. (I) and (II) read as follows:

''(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this subchapter under section 426(a) of this title, and

''(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.''

Subsec. (b)(1)(A)(ii). Pub. L. 103–66, §13561(e)(1)(B), substituted ''unless the plan is a plan of, or contributed to by, an employer or employee organization that has 20 or more individuals in current employment status'' for ''unless the plan is sponsored by or contributed to by an employer that has 20 or more employees''.

Subsec. (b)(1)(A)(iii). Pub. L. 103–66, §13561(e)(1)(C), substituted ''by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and'' for ''by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or''.

Subsec. (b)(1)(A)(iv). Pub. L. 103–66, §13561(c)(2), substituted ''Subparagraph (C) shall apply instead of clause (i)'' for ''Clause (i) shall not apply'' and inserted ''(without regard to entitlement under section 426 of this title)'' after ''individual is, or''.

Subsec. (b)(1)(A)(v). Pub. L. 103–66, §13561(e)(1)(D), as amended by Pub. L. 103–432, §151(c)(9)(B), inserted before period at end '', without regard to section 5000(d) of such Code''.

Subsec. (b)(1)(B). Pub. L. 103–66, §13561(e)(1)(E), substituted ''individuals'' for ''active individuals'' in heading.

Subsec. (b)(1)(B)(i). Pub. L. 103–66, §13561(e)(1)(F), substituted ''clause (iv)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer'' for ''clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I))''.

Subsec. (b)(1)(B)(ii). Pub. L. 103–66, §13561(c)(2), substituted ''Subparagraph (C) shall apply instead of clause (i)'' for ''Clause (i) shall not apply'' and inserted ''(without regard to entitlement under section 426 of this title)'' after ''individual is, or''.

Subsec. (b)(1)(B)(iii). Pub. L. 103–66, §13561(b), substituted ''1998'' for ''1995''.

Subsec. (b)(1)(B)(iv). Pub. L. 103–66, §13561(e)(1)(G), amended heading and text generally. Prior to amendment, text defined ''active individual'' and ''large group health plan''.

Subsec. (b)(1)(C). Pub. L. 103–66, §13561(c)(1), (3), substituted ''or eligible for benefits under this subchapter under'' for ''benefits under this subchapter solely by reason of'' in cl. (i) and concluding provisions and substituted ''before October 1, 1998'' for ''on or before January 1, 1996'' in concluding provisions.

Subsec. (b)(1)(E). Pub. L. 103–66, §13561(e)(1)(H), added cls. (ii) and (iii).

Pub. L. 103–66, §13561(d)(1), added subpar. (E).

Subsec. (b)(5)(B). Pub. L. 103–66, §13581(b)(1)(A), substituted ''under—'' for ''under subparagraph (A) for the purposes of carrying out this subsection.'' and added cls. (i) and (ii) and concluding provisions.

Subsec. (b)(5)(C)(i). Pub. L. 103–66, §13581(b)(1)(B), substituted ''subparagraph (B)(i)'' for ''subparagraph (B)''.

Subsec. (b)(5)(C)(iii). Pub. L. 103–66, §13561(a)(1), substituted ''1998'' for ''1995''.

1990—Subsec. (a). Pub. L. 101–508, §4161(a)(3)(C)(iii), inserted at end ''Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title.''

Subsec. (a)(1)(A). Pub. L. 101–508, §4163(d)(2)(A)(i), substituted ''a succeeding subparagraph'' for ''subparagraph (B), (C), (D), or (E)''.

Subsec. (a)(1)(F). Pub. L. 101–508, §4163(d)(2)(A)(ii)–(iv), added subpar. (F).

Subsec. (a)(2). Pub. L. 101–508, §4161(a)(3)(C)(i), inserted before semicolon at end '', except in the case of Federally qualified health center services''.

Subsec. (a)(3). Pub. L. 101–508, §4161(a)(3)(C)(ii), inserted '', in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title,'' after ''section 1395x(aa)(1) of this title,''.

Subsec. (a)(7). Pub. L. 101–508, §4163(d)(2)(B), inserted ''or under paragraph (1)(F)'' after ''paragraph (1)(B)''.

Pub. L. 101–508, §4153(b)(2)(B), inserted ''(other than eyewear described in section 1395x(s)(8) of this title)'' after first reference to ''eyeglasses''.

Subsec. (a)(14). Pub. L. 101–508, §4157(c)(1), inserted '', services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist,'' after ''this paragraph)'' and struck out before semicolon at end ''or are services of a certified registered nurse anesthetist''.

Subsec. (a)(15). Pub. L. 101–508, §4107(b), designated existing provisions as par. (A), substituted '', or'' for ''; or'' at end, and added par. (B).

Subsec. (b)(1)(B)(iii). Pub. L. 101–508, §4203(b), substituted ''October 1, 1995'' for ''January 1, 1992''.

Subsec. (b)(1)(C). Pub. L. 101–508, §4203(c)(1)(B), inserted at end ''Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting '18-month' for '12-month' each place it appears.''

Subsec. (b)(1)(C)(i). Pub. L. 101–508, §4203(c)(1)(A), substituted ''during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and'' for ''during the 12-month period which begins with the earlier of—

''(I) the month in which a regular course of renal dialysis is initiated, or

''(II) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under part A of this subchapter (if he had filed an application for such benefits) under the provisions of section 426–1(b)(1)(B) of this title; and''.

Subsec. (b)(3)(C). Pub. L. 101–508, §4204(g)(1), added subpar. (C).

Subsec. (b)(5)(C)(iii). Pub. L. 101–508, §4203(a)(1), substituted ''September 30, 1995'' for ''September 30, 1991''.

1989—Pub. L. 101–239, §6202(b)(1)(A), inserted ''and medicare as secondary payer'' in section catchline.

Subsec. (a)(1)(A). Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(2)(A)(i), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(E). Pub. L. 101–239, §6103(b)(3)(B), substituted ''section 1320b–12'' for ''section 1395*ll*(c)''.

Subsec. (a)(1)(F). Pub. L. 101–239, §6115(b), inserted before semicolon at end '', and, in the case of screening pap smear, which is performed more frequently than is provided under 1395x(nn) of this title''.

Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(2)(A)(ii)–(iv), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(G), (6), (7). Pub. L. 101–234 repealed Pub. L. 100–360, §§204(d)(2)(B), 205(e)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(14). Pub. L. 101–239, §6003(g)(3)(D)(xi), substituted ''hospital or rural primary care hospital'' for ''hospital'' in three places.

Subsec. (b). Pub. L. 101–239, §6202(b)(1)(B), amended heading and text generally, substituting pars. (1) to (4) relating to medicare as secondary payer for former pars. (1) to (5) relating to items or services paid under workmen's compensation laws and end stage renal disease program.

Subsec. (b)(1)(D). Pub. L. 101–239, §6202(e)(1), added subpar. (D).

Subsec. (b)(5). Pub. L. 101–239, §6202(a)(2)(A), added par. (5).

Subsec. (c). Pub. L. 101–234 repealed Pub. L. 100–360, §202(d), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e)(1). Pub. L. 101–239, §6411(d)(2), inserted '', not including items or services furnished in an emergency room of a hospital'' after ''(other than an emergency item or service''.

1988—Subsec. (a)(1)(A). Pub. L. 100–360, §204(d)(2)(A)(i), substituted ''a succeeding subparagraph'' for ''subparagraph (B), (C), (D), or (E)''.

Subsec. (a)(1)(F). Pub. L. 100–360, §204(d)(2)(A)(ii)–(iv), added subpar. (F) relating to screening mammography.

Subsec. (a)(1)(G). Pub. L. 100–360, §205(e)(1)(A), as amended by Pub. L. 100–485, §608(d)(7), added subpar. (G) relating to in-home care for chronically dependent individuals.

Subsec. (a)(6). Pub. L. 100–360, §205(e)(1)(B), inserted ''and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)'' after ''paragraph (1)(C)''.

Subsec. (a)(7). Pub. L. 100–360, §204(d)(2)(B), inserted ''or under paragraph (1)(F)'' after ''(1)(B)''.

Subsec. (a)(15). Pub. L. 100–360, §411(f)(4)(D)(i), inserted ''(including subsequent insertion of an intraocular lens)'' after ''operation''.

Subsec. (c). Pub. L. 100–360, §202(d), designated existing provisions as par. (1), redesignated former par. (1) as subpar. (A), redesignated former subpars. (A) to (D) as cls. (i) to (iv), redesignated former par. (2) as subpar. (B), redesignated former subpar. (A) as cl. (i) and substituted ''subparagraph (A)'' for ''paragraph (1)'', redesignated former subpar. (B) as cl. (ii), and added par. (2) prohibiting payment for expenses incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days with an exception.

Subsec. (e)(1). Pub. L. 100–360, §411(i)(4)(D)(i), as amended by Pub. L. 100–485, §608(d)(24)(C)(i), designated existing provisions of subsec. (e) as par. (1), redesignated former par. (1) as subpar. (A), substituted '', 1320a–7a, 1320c–5 or 1395u(j)(2)'' for ''or section

1320a–7a'', and redesignated former par. (2) as subpar. (B).

Subsec. (e)(2). Pub. L. 100–360, § 411(i)(4)(D)(ii), as amended by Pub. L. 100–485, § 608(d)(24)(C)(ii), amended former section 1395aaa of this title by striking out the catchline ''Limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities'', substituting ''(2)'' for the section designation, inserting ''1395u(j)(2),'' in text, and transferring the text to par. (2) of subsec. (e) of this section.

1987—Subsec. (a)(1)(A). Pub. L. 100–203, § 4085(i)(15), substituted ''(D), or (E)'' for ''or (D)''.

Subsec. (a)(8). Pub. L. 100–203, § 4072(c), inserted '', other than shoes furnished pursuant to section 1395x(s)(12) of this title'' before semicolon.

Subsec. (a)(14). Pub. L. 100–203, § 4085(i)(16), substituted ''a patient'' for ''an patient''.

Pub. L. 100–203, § 4009(j)(6)(C), made technical amendment to Pub. L. 99–509, § 9320(h)(1). See 1986 Amendment note below.

Subsec. (b)(2)(A)(ii). Pub. L. 100–203, § 4036(a)(1), substituted ''can reasonably be expected to be made under such a plan'' for ''the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this subchapter''.

Subsec. (b)(4)(B)(i). Pub. L. 100–203, § 4034(a), substituted ''subsection (b) of section 5000 of the Internal Revenue Code of 1986 without regard to subsection (d) of such section'' for ''section 5000(b) of the Internal Revenue Code of 1986''.

Subsec. (d). Pub. L. 100–93, § 8(c)(1)(A), struck out subsec. (d), which provided that no payment be made under this subchapter for any item or services to an individual by a person where Secretary determines such person knowingly and willfully made any false statement or representation of a material fact, submitted excessive bills or requests, or furnished excessive services or supplies, and provided a dissatisfied person with a hearing on determination of the Secretary.

Subsec. (e) [formerly § 1395aaa]. Pub. L. 100–93, § 10, added par. (2). See 1988 Amendment note above.

Pub. L. 100–93, § 8(c)(1)(B), amended subsec. (e) generally. Prior to amendment, subsec. (e) read as follows: ''No payment may be made under this subchapter with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1320a–7 of this title from participation in the program under this subchapter.''

Subsec. (h)(1)(B). Pub. L. 100–203, § 4039(c)(1)(A), substituted ''law (and any amount paid to a provider under any such warranty),'' for ''law,''.

Subsec. (h)(1)(D). Pub. L. 100–203, § 4039(c)(1)(B), inserted ''in determining the amount subject to repayment under paragraph (2)(C),'' after ''(3),''.

Subsec. (h)(2)(C). Pub. L. 100–203, § 4039(c)(1)(C), added subpar. (C).

Subsec. (h)(4). Pub. L. 100–93, § 8(c)(3), substituted ''subsections (c), (f), and (g) of section 1320a–7 of this title'' for ''paragraphs (2) and (3) of subsection (d) of this section''.

Subsec. (h)(4)(B). Pub. L. 100–203, § 4039(c)(1)(D), substituted '', has improperly'' for ''or has improperly'' and inserted ''or has failed to make repayment to the Secretary as required under paragraph (2)(C),'' after ''(2)(B),''.

1986—Subsec. (a)(1)(E). Pub. L. 99–509, § 9316(b), added subpar. (E).

Subsec. (a)(14). Pub. L. 99–509, § 9343(c)(1), substituted ''patient'' for ''inpatient''.

Pub. L. 99–509, § 9320(h)(1), as amended by Pub. L. 100–203, § 4009(j)(6)(C), inserted ''or are services of a certified registered nurse anesthetist'' after ''hospital'' at end.

Subsec. (a)(15). Pub. L. 99–272, § 9307(a), added par. (15).

Subsec. (a)(16). Pub. L. 99–272, § 9401(c)(1), added par. (16).

Subsec. (b)(2)(A). Pub. L. 99–514 substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954''.

Subsec. (b)(3)(A)(i). Pub. L. 99–272, § 9201(a)(1), substituted ''(or to the spouse of such individual)'' for ''who is under 70 years of age during any part of such month (or to the spouse of such individual, if the spouse is under 70 years of age during any part of such month)''.

Subsec. (b)(3)(A)(iii). Pub. L. 99–272, § 9201(a)(2), struck out ''and ending with the month before the month in which such individual attains the age of 70'' after ''section 426(a) of this title''.

Subsec. (b)(3)(A)(iv). Pub. L. 99–514 substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954''.

Subsec. (b)(4). Pub. L. 99–509, § 9319(a), added par. (4).

Subsec. (b)(5). Pub. L. 99–509, § 9319(b), added par. (5).

1984—Subsec. (a)(12). Pub. L. 98–369, § 2354(b)(30), struck out second comma after ''dental procedure''.

Subsec. (b)(1). Pub. L. 98–369, § 2344(a), substituted ''to be made promptly'' for ''to be made'' and ''has been or could be made under such a law'' for ''has been made under such a law'', and inserted ''In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a law, policy, plan, or insurance, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such law, policy, plan, or insurance, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a law, policy, plan, or insurance.''

Subsec. (b)(2)(B). Pub. L. 98–369, § 2344(b), substituted ''has been or could be made under a plan'' for ''has been made under a plan'', and inserted ''In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a plan.''

Subsec. (b)(3)(A)(i). Pub. L. 98–369, § 2301(a), struck out ''over 64 but'' before ''under 70 years'' in two places.

Subsec. (b)(3)(A)(ii). Pub. L. 98–369, § 2344(c), substituted ''has been or could be made under a group health plan'' for ''has been made under a group health plan'', and inserted ''In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a plan.''

Subsec. (b)(3)(A)(iii). Pub. L. 98–369, § 2354(b)(31), inserted ''before the month'' after ''ending with the month''.

Subsec. (h). Pub. L. 98–369, § 2304(c), added subsec. (h).

Subsec. (i). Pub. L. 98–369, § 2313(c), added subsec. (i).

1983—Subsec. (a)(1)(A). Pub. L. 98–21, § 601(f)(1), inserted reference to subpar. (D).

Subsec. (a)(1)(D). Pub. L. 98–21, § 601(f)(2)–(4), added subpar. (D).

Subsec. (a)(14). Pub. L. 98–21, §602(e), added par. (14).

Subsec. (b)(3)(A)(i). Pub. L. 97–448 inserted ''in any month'' after ''service furnished'', and ''during any part of such month'' after ''70 years of age'' wherever appearing.

1982—Subsec. (a)(1). Pub. L. 97–248, §122(f)(1), designated existing provisions as subpars. (A) and (B), in subpar. (A) as so designated inserted exception to provisions for items and services described in subpar. (B) or (C), substituted ''and'' for ''or'' as the connector between provisions, and added subpar. (C).

Subsec. (a)(6). Pub. L. 97–248, §122(f)(2), inserted ''(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))''.

Subsec. (a)(7). Pub. L. 97–248, §122(f)(3), substituted ''paragraph (1)(B)'' for ''paragraph (1)''.

Subsec. (a)(9). Pub. L. 97–248, §122(f)(4), inserted ''(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))''.

Subsec. (b)(1). Pub. L. 97–248, §128(a)(2), struck out ''or plan'' after ''service has been made under such a law''.

Subsec. (b)(2)(A). Pub. L. 97–248, §128(a)(3), substituted ''section 162(i)(2)'' for ''section 162(h)(2)''.

Subsec. (b)(2)(B). Pub. L. 97–248, §128(a)(4), inserted ''furnished'' before ''to an individual''.

Subsec. (b)(3). Pub. L. 97–248, §116(b), added par. (3).

Subsec. (d)(1)(C). Pub. L. 97–248, §148(a), substituted ''on the basis of information acquired by the Secretary in the administration of this subchapter'' for '', on the basis of reports transmitted to him in accordance with section 1320c–6 of this title (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this subchapter),''.

Subsec. (f). Pub. L. 97–248, §122(g)(1), substituted ''paragraph (1)(A)'' for ''paragraph (1)''.

Subsec. (g). Pub. L. 97–248, §142, added subsec. (g).

1981—Subsec. (b). Pub. L. 97–35, §2146(a), designated existing provisions as par. (1) and added par. (2).

Subsec. (c). Pub. L. 97–35, §2103(a)(1), added subsec. (c).

Subsec. (f). Pub. L. 97–35, §2152(a), added subsec. (f).

1980—Subsec. (a)(1). Pub. L. 96–611, §1(a)(3)(A), inserted '', or, in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness'' after ''of a malformed body member''.

Subsec. (a)(7). Pub. L. 96–611, §1(a)(3)(B), inserted ''(except as otherwise allowed under section 1395x(s)(10) of this title and paragraph (1))'' after ''immunizations''.

Subsec. (a)(12). Pub. L. 96–499, §936(c), inserted ''or because of the severity of the dental procedure,'' after ''and clinical status''.

Subsec. (a)(13)(C). Pub. L. 96–499, §939(a), struck out '', warts,'' after ''corns''.

Subsec. (b). Pub. L. 96–499, §953, inserted ''or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance'' and '', policy, plan, or insurance'' after ''or a State'' and '', policy, plan, or insurance'' after ''law or plan'' and inserted provision authorizing the Secretary to waive the provisions of this subsection in the case of an individual claim if he determined that the probability of recovery or amount involved did not warrant the pursuit of the claim.

Subsec. (d)(4). Pub. L. 96–272 added par. (4).

Subsec. (e). Pub. L. 96–499, §913(b), substituted provisions barring payment under this subchapter with respect to items or services furnished by a physician or other individual during a period when such physician or other individual was barred pursuant to section 1320a–7 of this title from participation under this subchapter for provisions authorizing the Secretary to suspend a physician or individual practitioner from participation under this subchapter upon determining that such physician or practitioner had been convicted of a criminal offense related to such physician's or practitioner's involvement in the programs under this subchapter or the program under subchapter XIX of this chapter.

1977—Subsec. (a)(3). Pub. L. 95–210 substituted ''except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, and in such other cases as the Secretary may specify'' for ''except in such cases as the Secretary may specify''.

Subsec. (d)(1)(B). Pub. L. 95–142, §13(b)(1), struck out requirement for concurrence of appropriate program review team for finding of Secretary under this paragraph.

Subsec. (d)(1)(C). Pub. L. 95–142, §13(b)(2), substituted provisions relating to determinations by the Secretary on the basis of reports transmitted to him in accordance with section 1320c–6 of this title or other data acquired in the administration of this subchapter, for provisions relating to determinations by the Secretary with the concurrence of appropriate review team members.

Subsec. (d)(4). Pub. L. 95–142, §13(a), struck out par. (4) which set forth provisions relating to appointment and functions of program review teams.

Subsec. (e). Pub. L. 95–142, §7(a), added subsec. (e).

1975—Subsec. (c). Pub. L. 94–182 struck out subsec. (c) prohibiting payments to Federal employees under this subchapter unless a determination and certification by the Secretary of a modification of any health benefits plan under chapter 89 of Title 5 was made which would allow a Federal employee benefits under part A or B of this subchapter.

1974—Subsec. (c). Pub. L. 93–480 substituted ''January 1, 1976'' for ''January 1, 1975''.

1973—Subsec. (a)(12). Pub. L. 93–233 substituted ''the provision of such dental services if the individual, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of such services'' for ''a dental procedure where the individual suffers from impairments of such severity as to require hospitalization''.

1972—Subsec. (a)(4). Pub. L. 92–603, §211(c)(1), inserted reference to physicians' services and ambulance services furnished an individual in conjunction with emergency inpatient hospital services.

Subsec. (a)(12). Pub. L. 92–603, §256(c), authorized payment under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization.

Subsec. (c). Pub. L. 92–603, §210, added subsec. (c).

Subsec. (d). Pub. L. 92–603, §229(a), added subsec. (d).

1968—Subsec. (a)(7). Pub. L. 90–248, §128, prohibited payment for procedures performed (during the course of any eye examination) to determine the refractive state of the eyes.

Subsec. (a)(13). Pub. L. 90–248, §127(b), added par. (13).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 2008(c), (d) of Pub. L. 115–271 applicable with respect to plan years beginning on or after Jan. 1, 2020, see section 2008(e) of Pub. L. 115–271, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title IV, §4009(b), Dec. 13, 2016, 130 Stat. 1185, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to local coverage determinations that are proposed or revised on or after the date that is 180 days after the date of enactment of this Act [Dec. 13, 2016].''

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title V, §516(b), Apr. 16, 2015, 129 Stat. 175, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 16, 2015] and shall apply to information required to be provided on or after January 1, 2016.''

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 112–242, title II, §202(b), Jan. 10, 2013, 126 Stat. 2380, provided that: ''The amendments made by sub-

section (a) [amending this section] shall apply to years beginning with 2014.''

Pub. L. 112–242, title II, § 205(b), Jan. 10, 2013, 126 Stat. 2381, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act [Jan. 10, 2013].''

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 4103(d) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 101(a)(3), (b)(3), (4) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 101(c) of Pub. L. 110–275, set out as a note under section 1395*l* of this title.

Pub. L. 110–275, title I, § 135(a)(2)(B), July 15, 2008, 122 Stat. 2535, provided that: ''The amendments made by this paragraph [amending this section] shall apply to advanced diagnostic imaging services furnished on or after January 1, 2012.''

Amendment by section 143(b)(7) of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Amendment by section 152(b)(1)(D) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2010, see section 152(b)(2) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title III, § 301(d), Dec. 8, 2003, 117 Stat. 2222, provided that: ''The amendments made by this section [amending this section] shall be effective—

''(1) in the case of subsection (a), as if included in the enactment of title III [sic] of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369); and

''(2) in the case of subsections (b) and (c), as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96–499; 94 Stat. 2647).''

Amendment by section 611(d)(1) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, but only for individuals whose coverage period under this part begins on or after such date, see section 611(e) of Pub. L. 108–173, set out as a note under section 1395w–4 of this title.

Amendment by section 612(c) of Pub. L. 108–173 applicable to tests furnished on or after Jan. 1, 2005, see section 612(d) of Pub. L. 108–173, set out as a note under section 1395x of this title.

Amendment by section 613(c) of Pub. L. 108–173 applicable to tests furnished on or after Jan. 1, 2005, see section 613(d) of Pub. L. 108–173, set out as a note under section 1395x of this title.

Pub. L. 108–173, title VII, § 731(a)(2), Dec. 8, 2003, 117 Stat. 2351, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to national coverage determinations as of January 1, 2004, and section 1862(*l*)(5) of the Social Security Act [42 U.S.C. 1395y(*l*)(5)], as added by such paragraph, shall apply to local coverage determinations made on or after July 1, 2004.''

Pub. L. 108–173, title VII, § 731(b)(2), Dec. 8, 2003, 117 Stat. 2351, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to routine costs incurred on and after January 1, 2005, and, as of such date, section 411.15(*o*) of title 42, Code of Federal Regulations, is superseded to the extent inconsistent with section 1862(m) of the Social Security Act [42 U.S.C. 1395y(m)], as added by such paragraph.''

Pub. L. 108–173, title IX, § 944(a)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to items and services furnished on or after January 1, 2004.''

Amendment by section 948(a) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554], see section 948(e) of Pub. L. 108–173, set out as a note under section 1314 of this title.

Pub. L. 108–173, title IX, § 950(b), Dec. 8, 2003, 117 Stat. 2427, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date that is 60 days after the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 2001 AMENDMENT

Pub. L. 107–105, § 3(b), Dec. 27, 2001, 115 Stat. 1007, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to claims submitted on or after October 16, 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title I, § 102(c)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, § 102(d)] of Pub. L. 106–554, set out as a note under section 1395x of this title.

Amendment by section 1(a)(6) [title III, § 313(a)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2001, see section 1(a)(6) [title III, § 313(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by section 1(a)(6) [title IV, § 432(b)(1)] of Pub. L. 106–554 applicable to services furnished on or after July 1, 2001 see section 1(a)(6) [title IV, § 432(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by section 1(a)(6) [title V, § 522(b)] of Pub. L. 106–554 applicable with respect to a review of any national or local coverage determination filed, a request to make such a determination made, and a national coverage determination made, on or after Oct. 1, 2001, see section 1(a)(6) [title V, § 522(d)] of Pub. L. 106–554, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 305(b)] of Pub. L. 106–113 applicable to payments for services provided on or after Nov. 29, 1999, see § 1000(a)(6) [title III, § 305(c)] of Pub. L. 106–113, set out as a note under section 1395u of this title.

Amendment by section 1000(a)(6) [title III, § 321(k)(10)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

Amendment by section 4022(b)(1)(B) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33, set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4102(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4103(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4104(c)(3) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4432(b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4507(a)(2)(B) of Pub. L. 105–33 applicable with respect to contracts entered into on and after Jan. 1, 1998, see section 4507(c) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 4511(a)(2)(C) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4541(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, including portions of cost reporting periods occurring on or after such date, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4603(c)(2)(C) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

Pub. L. 105–33, title IV, §4614(c), Aug. 5, 1997, 111 Stat. 475, provided that: ''The amendments made by this section [amending this section] apply to services furnished on or after October 1, 1997.''

Pub. L. 105–33, title IV, §4632(b), Aug. 5, 1997, 111 Stat. 486, provided that: ''The amendments made by this section [amending this section] apply to items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, §4633(c), Aug. 5, 1997, 111 Stat. 487, provided that: ''The amendments made by this section [amending this section] apply to items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].''

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 145(c)(1) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Amendment by section 147(e)(6) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, §151(a)(2)(B), Oct. 31, 1994, 108 Stat. 4433, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply with respect to items and services furnished on or after the expiration of the 120-day period beginning on the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, §151(b)(3)(C), Oct. 31, 1994, 108 Stat. 4434, provided that: ''The amendments made by this paragraph [amending this section] shall apply to payments for items and services furnished on or after the date of the enactment of this Act [Oct. 31, 1994].''

Pub. L. 103–432, title I, §151(c)(1), (9), Oct. 31, 1994, 108 Stat. 4435, 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

Pub. L. 103–432, title I, §151(c)(4), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–508.

Pub. L. 103–432, title I, §151(c)(5), (6), Oct. 31, 1994, 108 Stat. 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Amendment by section 156(a)(2)(D) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

Pub. L. 103–432, title I, §157(b)(8), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The amendments made by this subsection [amending this section, section 1395mm of this title, and provisions set out as notes under section 1395mm of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–432, title I, §151(c)(10), Oct. 31, 1994, 108 Stat. 4436, provided that: ''The amendment made by section 13561(e)(1)(G) of OBRA–1993 [Pub. L. 103–66, amending this section], to the extent it relates to the definition of large group health plan, shall be effective as if included in the enactment of OBRA–1989 [Pub. L. 101–239].''

Amendment by section 13561(d)(1) of Pub. L. 103–66 effective 90 days after Aug. 10, 1993, see section 13561(d)(3) of Pub. L. 103–66, set out as a note under section 5000 of Title 26, Internal Revenue Code.

Pub. L. 103–66, title XIII, §13561(e)(1)(D), Aug. 10, 1993, 107 Stat. 595, as amended by Pub. L. 103–432, title I, §151(c)(9)(A), Oct. 31, 1994, 108 Stat. 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Pub. L. 103–66, title XIII, §13581(d), Aug. 10, 1993, 107 Stat. 611, provided that: ''The amendments made by this section [enacting section 1320b–14 of this title and amending this section, section 1396a of this title, and section 552a of Title 5, Government Organization and Employees] shall take effect on January 1, 1994.''

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4153(b)(2)(B) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(b)(2)(C) of Pub. L. 101–508, set out as a note under section 1395x of this title.

Amendment by section 4157(c)(1) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(3)(C) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(d)(2)(A)(i)–(iii), (B) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, as amended, set out as a note under section 1395*l* of this title.

Pub. L. 101–508, title IV, §4163(d)(3), as added by Pub. L. 103–432, title I, §147(f)(5)(A), Oct. 31, 1994, 108 Stat. 4431, provided that: ''The amendment made by paragraph (2)(A)(iv) [amending this section] shall apply to screening pap smears performed on or after July 1, 1990.''

Pub. L. 101–508, title IV, §4204(g)(2), Nov. 5, 1990, 104 Stat. 1388–112, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to incentives offered on or after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(b) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by section 6202(b)(1) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 101–239, title VI, § 6202(e)(2), Dec. 19, 1989, 103 Stat. 2235, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to items and services furnished on or after October 1, 1989.''

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(d) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 204(d)(2) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(i)(4)(D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, § 411(f)(4)(D)(ii), July 1, 1988, 102 Stat. 778, provided that: ''The amendment made by clause (i) [amending this section] shall apply to operations performed on or after 60 days after the date of the enactment of this Act [July 1, 1988].''

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4009(j)(6), Dec. 22, 1987, 101 Stat. 1330–59, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, § 4034(b), Dec. 22, 1987, 101 Stat. 1330–77, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 9319(a) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Pub. L. 100–203, title IV, § 4036(a)(2), Dec. 22, 1987, 101 Stat. 1330–79, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to items and services furnished on or after 30 days after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4039(c)(2), Dec. 22, 1987, 101 Stat. 1330–82, provided that: ''The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988.''

For effective date of amendment by section 4072(c) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9319(f), Oct. 21, 1986, 100 Stat. 2013, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [enacting section 5000 of Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395r of this title] shall apply to items and services furnished on or after January 1, 1987.

''(2) The amendments made by subsection (c) [amending sections 1395p and 1395r of this title] shall apply to enrollments occurring on or after January 1, 1987.''

Amendment by section 9320(h)(1) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Amendment by section 9343(c)(1) of Pub. L. 99–509 applicable to services furnished after June 30, 1987, see section 9343(h)(2) of Pub. L. 99–509, as amended, set out as a note under section 1395*l* of this title.

Pub. L. 99–272, title IX, § 9201(d)(1), Apr. 7, 1986, 100 Stat. 171, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after May 1, 1986.''

Amendment by section 9307(a) of Pub. L. 99–272 applicable to services performed on or after Apr. 1, 1986, see section 9307(e) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2301(c)(1), July 18, 1984, 98 Stat. 1063, provided that: ''The amendment made by subsection (a) [amending this section] shall be effective with respect to items and services furnished on or after January 1, 1985.''

Amendment by section 2304(c) of Pub. L. 98–369 applicable to pacemaker devices and leads implanted or removed on or after the effective date of final regulations promulgated to carry out such amendment, see section 2304(d) of Pub. L. 98–369, set out as a note below.

Pub. L. 98–369, div. B, title III, § 2313(e), July 18, 1984, 98 Stat. 1079, provided that: ''The amendments made by this section [amending this section and section 1395ww of this title] shall become effective on the date of the enactment of this Act [July 18, 1984].''

Pub. L. 98–369, div. B, title III, § 2344(d), July 18, 1984, 98 Stat. 1096, provided that: ''The amendments made by this section [amending this section] shall apply to items and services furnished on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(30), (31) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 601(f) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, and amendment by section 602(e)(3) of Pub. L. 98–21 effective Oct. 1, 1983, see section 604(a)(1), (2) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 116(b) of Pub. L. 97–248 applicable with respect to items and services furnished on or after Jan. 1, 1983, see section 116(c) of Pub. L. 97–248, set out as a note under section 623 of Title 29, Labor.

Amendment by section 122(f), (g)(1) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(a)(2)–(4) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by sections 142 and 148(a) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2103(a)(2), Aug. 13, 1981, 95 Stat. 787, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to expenses incurred on or after October 1, 1981.''

Pub. L. 97–35, title XXI, §2146(c)(1), Aug. 13, 1981, 95 Stat. 801, provided that: ''The amendments made by subsection (a) [amending this section] shall become effective on October 1, 1981.''

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395*l* of this title.

Amendment by section 936(c) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Pub. L. 96–499, title IX, §939(b), Dec. 5, 1980, 94 Stat. 2640, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished on or after July 1, 1981.''

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Pub. L. 95–142, §13(c), Oct. 25, 1977, 91 Stat. 1198, provided that: ''The amendments made by this section [amending this section and sections 1320c–6 and 1395cc of this title] shall take effect on the date of the enactment of this Act [Oct. 25, 1977].''

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective with respect to admissions subject to the provisions of section 1395(a)(2) of this title which occur after Dec. 31, 1973, see section 18(z–3)(2) of Pub. L. 93–233, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(c)(1) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 256(c) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 127(b) of Pub. L. 90–248 applicable with respect to services furnished after Dec. 31, 1967, see section 127(c) of Pub. L. 90–248, set out as a note under section 1395x of this title.

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 153(b)(2) of Pub. L. 110–275, see section 153(b)(4) of Pub. L. 110–275, set out as a note under section 1395rr of this title.

CONSTRUCTION OF 2007 AMENDMENT

Pub. L. 110–173, title I, §111(b), Dec. 29, 2007, 121 Stat. 2499, provided that: ''Nothing in the amendments made by this section [amending this section] shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], including under parts C and D of such title.''

CONSTRUCTION OF 2003 AMENDMENT

Pub. L. 108–173, title VII, §731(b)(3), Dec. 8, 2003, 117 Stat. 2351, provided that: ''Nothing in the amendment made by paragraph (1) [amending this section] shall be construed as applying to, or affecting, coverage or payment for a nonexperimental/investigational (category B) device.''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS

Pub. L. 108–173, title IX, §943, Dec. 8, 2003, 117 Stat. 2422, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act [42 U.S.C. 1395y(b)] (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

''(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A [probably means part A of title XVIII of the Social Security Act which is classified to part A of this subchapter] or enrolled under part B [probably means part B of title XVIII of the Social Security Act which is classified to 42 U.S.C. 1395j et seq.], or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.''

ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS

Pub. L. 108–173, title IX, §953(b), Dec. 8, 2003, 117 Stat. 2428, provided that: ''The Secretary [of Health and

Human Services] shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in the previous year and information on how to get more information with respect to such determinations.''

NOTIFICATION TO PHYSICIANS OF EXCESSIVE HOME HEALTH VISITS

Pub. L. 105–33, title IV, § 4614(b), Aug. 5, 1997, 111 Stat. 474, provided that: ''The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health visits, furnished under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] pursuant to a prescription or certification of the physician, significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.''

DISTRIBUTION OF QUESTIONNAIRE BY CONTRACTOR

Pub. L. 103–432, title I, § 151(a)(1)(B), Oct. 31, 1994, 108 Stat. 4433, provided that: ''The Secretary of Health and Human Services shall enter into an agreement with an entity not later than 60 days after the date of the enactment of the Social Security Act Amendments of 1994 [Oct. 31, 1994], to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act [42 U.S.C. 1395y(b)(5)(D)] (as added by subparagraph (A)).''

RETROACTIVE EXEMPTION FOR CERTAIN SITUATIONS INVOLVING RELIGIOUS ORDERS

Pub. L. 103–66, title XIII, § 13561(f), Aug. 10, 1993, 107 Stat. 595, provided that: ''Section 1862(b)(1)(D) of the Social Security Act [42 U.S.C. 1395y(b)(1)(D)] applies, with respect to items and services furnished before October 1, 1989, to any claims that the Secretary of Health and Human Services had not identified as of that date as subject to the provisions of section 1862(b) of such Act.''

GAO STUDY OF EXTENSION OF SECONDARY PAYER PERIOD

Pub. L. 101–508, title IV, § 4203(c)(2), Nov. 5, 1990, 104 Stat. 1388–108, as amended by Pub. L. 103–432, title I, § 151(c)(7), Oct. 31, 1994, 108 Stat. 4436, directed Comptroller General to conduct study of impact of second sentence of subsec. (b)(1)(C) of this section and to submit preliminary report to Congress not later than Jan. 1, 1993, and final report not later than Jan. 1, 1995.

DEADLINE FOR FIRST TRANSMITTAL AND REQUEST OF MATCHING INFORMATION

Pub. L. 101–239, title VI, § 6202(a)(2)(B), Dec. 19, 1989, 103 Stat. 2229, provided that: ''The Commissioner of Social Security shall first—

''(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act [42 U.S.C. 1395y(b)(5)(A)(i)] (as inserted by subparagraph (A)), and

''(ii) request from the Secretary disclosure of information described in section 6013(*l*)(12)(A) of the Internal Revenue Code of 1986 [26 U.S.C. 6013(*l*)(12)(A)],

by not later than 14 days after the date of the enactment of this Act [Dec. 19, 1989].''

DESIGNATION OF PEDIATRIC HOSPITALS AS MEETING CERTIFICATION AS HEART TRANSPLANT FACILITY

Pub. L. 100–203, title IV, § 4009(b), Dec. 22, 1987, 101 Stat. 1330–57, provided that: ''For purposes of determining whether a pediatric hospital that performs pediatric heart transplants meets the criteria established by the Secretary of Health and Human Services for facilities in which the heart transplants performed will be considered to meet the requirement of section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], the Secretary shall treat such a hospital as meeting such criteria if—

''(1) the hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria,

''(2) the unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria), and

''(3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.''

APPROVAL OF SURGICAL ASSISTANTS FOR PROCEDURES PERFORMED APRIL 1, 1986, TO DECEMBER 15, 1986

Pub. L. 99–514, title XVIII, § 1895(b)(16)(C), Oct. 22, 1986, 100 Stat. 2934, provided that: ''For purposes of section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)), added by section 9307(a)(3) of COBRA, and for surgical procedures performed during the period beginning on April 1, 1986, and ending on December 15, 1986, a carrier is deemed to have approved the use of an assistant in a surgical procedure, before the surgery is performed, based on the existence of a complicating medical condition if the carrier determines after the surgery is performed that the use of the assistant in the procedure was appropriate based on the existence of a complicating medical condition before or during the surgery.''

EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS

Pub. L. 99–509, title IX, § 9305(f), Oct. 21, 1986, 100 Stat. 1991, as amended by Pub. L. 100–360, title IV, § 426(a), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, § 4008(a)(2), Nov. 5, 1990, 104 Stat. 1388–44, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act [42 U.S.C. 1395y(a)(1)(C)], apply (under section 1879(a) of such Act [42 U.S.C. 1395pp(a)]) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act [Oct. 21, 1986] and before December 31, 1995.''

[Pub. L. 101–508, title IV, § 4008(a)(3), Nov. 5, 1990, 104 Stat. 1388–44, provided that: ''The amendments made by paragraphs (1) and (2) [amending section 9305(f) of Pub. L. 99–509, set out above, and section 9126(c) of Pub. L. 99–272, set out below] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].'']

STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY OF AMENDMENTS RELATING TO LARGE GROUP HEALTH PLANS AND MEDICARE AS SECONDARY PAYER

Pub. L. 99–509, title IX, § 9319(e), Oct. 21, 1986, 100 Stat. 2012, directed Comptroller General to study and report to Congress, not later than Mar. 1, 1990, the impact of the amendments made by this section (enacting section 5000 of Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395r of this title) on access of disabled individuals and members of their family to employment and health insurance, such report to include information relating to number of disabled medicare beneficiaries for whom medicare has become secondary, either through their employment or the employment of a family member, amount of savings to the medicare program achieved annually through this provision, and effect on employment, and employment-based health coverage, of disabled individuals and family members.

REINSTATEMENT OF WAIVER OF LIABILITY PRESUMPTION

Pub. L. 99–272, title IX, § 9126(c), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 100–360, title IV, § 426(b),

July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, §4008(a)(1), Nov. 5, 1990, 104 Stat. 1388–44, provided that: ''The Secretary of Health and Human Services shall, for purposes of determining whether payments to a skilled nursing facility should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], apply the same presumption of compliance (5 percent) as in effect under regulations as of July 1, 1985. Such presumption shall apply for the period beginning with the first month beginning after the date of the enactment of this Act [Apr. 7, 1986] and ending on December 31, 1995.''

HOME HEALTH WAIVER OF LIABILITY

Pub. L. 99–272, title IX, §9205, Apr. 7, 1986, 100 Stat. 178, as amended by Pub. L. 100–360, title IV, §426(d), July 1, 1988, 102 Stat. 814; Pub. L. 103–432, title I, §158(b)(1), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The Secretary of Health and Human Services shall, for purposes of determining whether payments to a home health agency should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], apply a presumption of compliance (2.5 percent) in the same manner as under the regulations in effect as of July 1, 1985. Such presumption shall apply until December 31, 1995.''

[Pub. L. 103–432, title I, §158(b)(2), Oct. 31, 1994, 108 Stat. 4443, provided that: ''The amendment made by paragraph (1) [amending section 9205 of Pub. L. 99–272, set out above] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].'']

RECOMMENDATIONS AND GUIDELINES FOR ELIMINATION OF ASSISTANTS AT SURGERY; REPORT TO CONGRESS

Pub. L. 99–272, title IX, §9307(d), Apr. 7, 1986, 100 Stat. 194, provided that the Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, develop recommendations and guidelines respecting other surgical procedures for which an assistant at surgery was generally not medically necessary and circumstances under which use of an assistant at surgery was generally appropriate but should be subject to prior approval of an appropriate entity and that the Secretary report to Congress, not later than January 1, 1987, on these recommendations and guidelines.

PACEMAKER REIMBURSEMENT REVIEW AND REFORM; PROMULGATION OF REGULATIONS; EFFECTIVE DATE OF PACEMAKER REGISTRATION

Pub. L. 98–369, div. B, title III, §2304(d), July 18, 1984, 98 Stat. 1069, provided that: ''The Secretary of Health and Human Services shall promulgate final regulations to carry out this section and the amendment made by this section [amending this section and enacting provisions set out as a note under section 1395*l* of this title] prior to January 1, 1985, and the amendment made by subsection (c) [amending this section] shall apply to pacemaker devices and leads implanted or removed on or after the effective date of such regulations.''

PAYMENT FOR DEBRIDEMENT OF MYCOTIC TOENAILS

Pub. L. 98–369, div. B, title III, §2325, July 18, 1984, 98 Stat. 1087, provided that: ''The Secretary shall provide, pursuant to section 1862(a) of the Social Security Act [42 U.S.C. 1395y(a)], that payment will not be made under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for a physician's debridement of mycotic toenails to the extent such debridement is performed for a patient more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing physician.''

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS' SERVICES

Pub. L. 98–21, title VI, §602(k), Apr. 20, 1983, 97 Stat. 165, as amended by Pub. L. 99–272, title IX, §9112(a), Apr. 7, 1986, 100 Stat. 163, provided that:

''(1) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act [42 U.S.C. 1395y(a)(14), 1395cc(a)(1)(H)] in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title [42 U.S.C. 1395c et seq.] shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

''(2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver.

''(3) Any waiver granted under paragraph (1) shall provide that, with respect to those items and services billed under part B of title XVIII of the Social Security Act solely by reason of such waiver—

''(A) payment under such part shall be equal to 100 percent of the reasonable charge or other applicable payment base for the items and services; and

''(B) the entity furnishing the items and services must agree to accept the amount paid pursuant to subparagraph (A) as the full charge for the items and services.''

[Pub. L. 99–272, title IX, §9112(b), Apr. 7, 1986, 100 Stat. 163, provided that:

[''(1) Section 602(k)(2) of the Social Security Amendments of 1983 (as added by subsection (a)) [set out above] shall apply to cost reporting periods beginning on or after January 1, 1986.

[''(2) Section 602(k)(3) of the Social Security Amendments of 1983 (as added by subsection (a)) [set out above] shall apply to items and services furnished after the end of the 10-day period beginning on the date of the enactment of this Act [Apr. 7, 1986].'']

PROHIBITION OF PAYMENT FOR INEFFECTIVE DRUGS

Pub. L. 97–248, title I, §115(b), Sept. 3, 1982, 96 Stat. 353, provided that: ''No provision of law limiting the use of funds for purposes of enforcing or implementing section 1862(c) [42 U.S.C. 1395y(c)] or section 1903(i)(5) [42 U.S.C. 1396b(i)(5)] of the Social Security Act, section 2103 of the Omnibus Budget Reconciliation Act of 1981 [section 2103 of Pub. L. 97–35, amending sections 1395y and 1396b of this title and enacting provisions set out as notes under sections 1395y and 1396b of this title], or any rule or regulation issued pursuant to any such section (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations) shall apply to any period after September 30, 1982, unless such provision of law is enacted after the date of the enactment of this Act [Sept. 3, 1982] and specifically states that such provision is to supersede this section.''

ESTABLISHMENT AND IMPLEMENTATION OF GUIDELINES

Pub. L. 97–35, title XXI, §2152(b), Aug. 13, 1981, 95 Stat. 802, directed the Secretary of Health and Human Services to establish, and provide for the implementation

of, the guidelines described in subsec. (f) of this section not later than Oct. 1, 1981.

REPORT TO CONGRESSIONAL COMMITTEES ON IMPLEMENTATION OF CERTIFICATION REQUIREMENTS RELATING TO MODIFICATION OF HEALTH BENEFITS PLAN OR PROGRAM; FAILURE TO SUBMIT REPORT

Pub. L. 93–480, § 4(b), Oct. 26, 1974, 88 Stat. 1454, provided that the Civil Service Commission and the Secretary of Health, Education, and Welfare submit a report on or before Mar. 1, 1975, on the steps which have been taken, and the steps which are planned, to enable the Secretary to make the determination and certification referred to in former subsec. (c) of this section and that if such report is not submitted by Mar. 1, 1975, the date specified in former subsec. (c) shall be deemed to be July 1, 1975, rather than Jan. 1, 1976.

§ 1395z. Consultation with State agencies and other organizations to develop conditions of participation for providers of services

In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (j)(15),[1] (*o*)(6), (cc)(2)(I), and[2] (dd)(2), and (mm)(1) of section 1395x of this title, or by ambulatory surgical centers under section 1395k(a)(2)(F)(i) of this title, the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under subchapter I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

(Aug. 14, 1935, ch. 531, title XVIII, § 1863, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 325; amended Pub. L. 92–603, title II, § 234(g)(2), Oct. 30, 1972, 86 Stat. 1413; Pub. L. 96–499, title IX, §§ 933(f), 934(c)(1), Dec. 5, 1980, 94 Stat. 2636, 2639; Pub. L. 97–248, title I, § 122(g)(2), Sept. 3, 1982, 96 Stat. 362; Pub. L. 98–369, div. B, title III, §§ 2335(c), 2349(b)(1), 2354(b)(32), July 18, 1984, 98 Stat. 1090, 1097, 1102; Pub. L. 100–360, title II, §§ 203(e)(2), 204(c)(1), July 1, 1988, 102 Stat. 725, 728; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, § 6003(g)(3)(C)(ii), Dec. 19, 1989, 103 Stat. 2152; Pub. L. 101–508, title IV, § 4163(c)(1), Nov. 5, 1990, 104 Stat. 1388–99; Pub. L. 103–432, title I, § 145(c)(2), Oct. 31, 1994, 108 Stat. 4427.)

Editorial Notes

REFERENCES IN TEXT

Subsection (j) of section 1395x of this title, referred to in text, was amended generally by Pub. L. 100–203, title IV, § 4201(a)(1), Dec. 22, 1987, 101 Stat. 1330–160, and, as so amended, does not contain a par. (15).

AMENDMENTS

1994—Pub. L. 103–432 struck out ''or whether screening mammography meets the standards established under section 1395m(c)(3) of this title,'' before ''the Secretary shall consult''.

1990—Pub. L. 101–508 inserted ''or whether screening mammography meets the standards established under section 1395m(c)(3) of this title,'' after ''section 1395k(a)(2)(F)(i) of this title,''.

1989—Pub. L. 101–239 substituted ''(jj)(3), and (mm)(1)'' for ''and (jj)(3)''.

Pub. L. 101–234 repealed Pub. L. 100–360, §§ 203(e)(2), 204(c)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted. In the case of the amendment by Pub. L. 100–360, § 203(e)(2), Pub. L. 101–234 was given effect by substituting ''and (dd)(2)'' for ''(dd)(2), (jj)(3)'' because of the intervening amendment by Pub. L. 101–239, see note above and 1988 Amendment note below.

1988—Pub. L. 100–360, § 204(c)(1), inserted ''or whether screening mammography meets the standards established under section 1395m(e)(3) of this title,'' after ''1395k(a)(2)(F)(i) of this title,''.

Pub. L. 100–360, § 203(e)(2), substituted ''(dd)(2), and (jj)(3)'' for ''and (dd)(2)''.

1984—Pub. L. 98–369, § 2335(c), struck out ''(g)(4),'' after ''(e)(9), (f)(4),''.

Pub. L. 98–369, § 2354(b)(32), substituted ''(j)(15)'' for ''(j)(11)''.

Pub. L. 98–369, § 2349(b)(1), substituted ''appropriate State agencies'' for ''the Health Insurance Benefits Advisory Council established by section 1395dd of this title, appropriate State agencies,''.

1982—Pub. L. 97–248 substituted ''(cc)(2)(I), and (dd)(2)'' for ''and (cc)(2)(I)''.

1980—Pub. L. 96–499, § 933(f), substituted ''(*o*)(6), and (cc)(2)(I) of section 1395x'' for ''and (*o*)(6) of section 1395x''.

Pub. L. 96–499, § 934(c)(1), inserted ''or by ambulatory surgical centers under section 1395k(a)(2)(F)(i) of this title,''.

1972—Pub. L. 92–603 substituted ''subsections (e)(9), (f)(4), (g)(4), (j)(11), and (*o*)(6) of section 1395x of this title'' for ''subsections (e)(8), (f)(4), (g)(4), (j)(10), and (*o*)(5) of section 1395x of this title''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(e)(2) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(c)(1) of Pub. L. 100–360 applicable to screening mammography performed on or

[1] See References in Text note below.

[2] So in original. The word ''and'' probably should not appear.

after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2335(c) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2349(b)(1) of Pub. L. 98–369 effective July 18, 1984, see section 2349(c) of Pub. L. 98–369, set out as a note under section 907a of this title.

Amendment by section 2354(b)(32) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 933(f) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after the fifth month following October 1972, see section 234(i) of Pub. L. 92–603, set out as a note under section 1395x of this title.

TERMINATION OF ADVISORY COUNCILS

Advisory councils in existence on Jan. 5, 1973, to terminate not later than the expiration of the 2-year period following Jan. 5, 1973, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law. See sections 3(2) and 14 of Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, 776, set out in the Appendix to Title 5, Government Organization and Employees.

§ 1395aa. Agreements with States

(a) Use of State agencies to determine compliance by providers of services with conditions of participation

The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or whether a facility therein is a rural health clinic as defined in section 1395x(aa)(2) of this title, a critical access hospital, as defined in section 1395x(mm)(1) of this title, or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title, or whether a laboratory meets the requirements of paragraphs (16) and (17) of section 1395x(s) of this title, or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1395x(p)(4) of this title, or whether an ambulatory surgical center meets the standards specified under section 1395k(a)(2)(F)(i) of this title, or whether a facility is a rural emergency hospital as defined in section 1395x(kkk)(2) of this title. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1395x of this title) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1395i–3(a) of this title. Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this subchapter and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies and hospice programs located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency or the hospice program, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency or the hospice program) and (2) to receive

complaints (and answer questions) with respect to home health agencies and hospice programs in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1395bb of this title, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

(b) Payment in advance or by way of reimbursement to State for performance of functions of subsection (a)

The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) Use of State or local agencies to survey hospitals

The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), provider entities that, pursuant to section 1395bb(a)(1) of this title, are treated as meeting the conditions or requirements of this subchapter. The Secretary shall pay for such services in the manner prescribed in subsection (b).

(d) Fulfillment of requirements by States

The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1395i–3(e) of this title and section 1395i–3(g) of this title and the establishment of remedies under sections 1395i–3(h)(2)(B) and 1395i–3(h)(2)(C) of this title (relating to establishment and application of remedies).

(e) Prohibition of user fees for survey and certification

Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1395rr(b)(1) of this title, for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this subchapter (other than any fee relating to section 263a of this title).

(Aug. 14, 1935, ch. 531, title XVIII, § 1864, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 326; amended Pub. L. 90–248, title I, § 133(f), title II, § 228(b), Jan. 2, 1968, 81 Stat. 852, 904; Pub. L. 92–603, title II, §§ 244(a), 277, 278(a)(16), (b)(15), 299D(a), Oct. 30, 1972, 86 Stat. 1422, 1452–1454, 1461; Pub. L. 95–210, § 1(i), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 96–499, title IX, §§ 933(g), 934(c)(2), Dec. 5, 1980, 94 Stat. 2637, 2639; Pub. L. 96–611, § 1(a)(2), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–248, title I, § 122(g)(3), Sept. 3, 1982, 96 Stat. 362; Pub. L. 98–369, div. B, title III, § 2354(b)(17), July 18, 1984, 98 Stat. 1101; Pub. L. 99–509, title IX, § 9320(h)(3), Oct. 21, 1986, 100 Stat. 2016; Pub. L. 100–203, title IV, §§ 4025(a), 4072(d), 4201(a)(2), (d)(4), 4202(a)(1), (c), 4203(a)(1), 4212(b), Dec. 22, 1987, 101 Stat. 1330–74, 1330–117, 1330–160, 1330–174, 1330–179, 1330–212, as amended Pub. L. 100–360, title IV, § 411(*l*)(1)(C), (6)(B), July 1, 1988, 102 Stat. 804, as amended Pub. L. 100–485, title VI, § 608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title II, §§ 203(e)(3), 204(c)(2), (d)(3), title IV, § 411(d)(4)(A), July 1, 1988, 102 Stat. 725, 728, 729, 774, as amended Pub. L. 100–485, title VI, § 608(d)(20)(B), (C), Oct. 13, 1988, 102 Stat. 2419, 2420; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6003(g)(3)(C)(iii), 6115(c), Dec. 19, 1989, 103 Stat. 2152, 2219; Pub. L. 101–508, title IV, §§ 4154(d)(1), 4163(c)(2), 4207(g), formerly 4027(g), Nov. 5, 1990, 104 Stat. 1388–85, 1388–100, 1388–123; Pub. L. 103–432, title I, §§ 145(c)(3), 160(a)(1), (d)(4), Oct. 31, 1994, 108 Stat. 4427, 4443, 4444; Pub. L. 104–134, title I, § 101(d) [title V, § 516(c)(1)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–247; renumbered title I, Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 105–33, title IV, §§ 4106(c), 4201(c)(1), Aug. 5, 1997, 111 Stat. 368, 373; Pub. L. 110–275, title I, § 125(b)(3), July 15, 2008, 122 Stat. 2519; Pub. L. 116–260, div. CC, title I, § 125(d)(2), title IV, § 407(a)(3)(A), Dec. 27, 2020, 134 Stat. 2966, 3007.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(d)(2) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment note below.

Editorial Notes

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–260, § 407(a)(3)(A), inserted ''and hospice programs'' after ''information on home health agencies'', ''or the hospice program'' after ''the home health agency'', ''or the hospice program'' after ''with respect to the agency'', and ''and hospice programs'' after ''with respect to home health agencies''.

Pub. L. 116–260, § 125(d)(2), inserted before period at end of first sentence '', or whether a facility is a rural emergency hospital as defined in section 1395x(kkk)(2) of this title''. Amendment was executed as if closing quotation marks preceded the period in the directory language, to reflect the probable intent of Congress.

2008—Subsec. (c). Pub. L. 110–275 substituted ''pursuant to section 1395bb(a)(1)'' for ''pursuant to subsection (a) or (b)(1) of section 1395bb''.

1997—Subsec. (a). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Pub. L. 105–33, § 4106(c), substituted ''paragraphs (16) and (17)'' for ''paragraphs (15) and (16)''.

1996—Subsec. (c). Pub. L. 104–134, in first sentence, substituted at end ''provider entities that, pursuant to subsection (a) or (b)(1) of section 1395bb of this title, are treated as meeting the conditions or requirements of this subchapter.'' for ''hospitals which have an agreement with the Secretary under section 1395cc of this title and which are accredited by the Joint Commission on Accreditation of Hospitals.''

1994—Subsec. (a). Pub. L. 103–432, § 160(a)(1)(B), struck out ''or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title'' after ''section 1395x(s) of this title'' in first sentence.

Pub. L. 103–432, § 145(c)(3), struck out '', or whether screening mammography meets the standards established under section 1395m(c)(3) of this title'' after ''section 1395k(a)(2)(F)(i) of this title'' in first sentence.

Subsec. (e). Pub. L. 103–432, § 160(a)(1)(A), inserted before period at end ''(other than any fee relating to section 263a of this title)''.

1990—Subsec. (a). Pub. L. 101–508, § 4163(c)(2), inserted before period at end of first sentence '', or whether screening mammography meets the standards established under section 1395m(c)(3) of this title''.

Pub. L. 101–508, § 4154(d)(1), substituted ''section 1395x(s) of this title or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title,'' for ''section 1395x(s) of this title,'' in first sentence.

Subsec. (e). Pub. L. 101–508, § 4207(g), formerly § 4027(g), as renumbered by Pub. L. 103–432, § 160(d)(4), added subsec. (e).

1989—Subsec. (a). Pub. L. 101–239, § 6115(c), substituted ''paragraphs (15) and (16)'' for ''paragraphs (14) and (15)''.

Pub. L. 101–239, § 6003(g)(3)(C)(iii), inserted '', a rural primary care hospital, as defined in section 1395x(mm)(1) of this title,'' after ''1395x(aa)(2) of this title''.

Pub. L. 101–234 repealed Pub. L. 100–360, §§ 203(e)(3), 204(c)(2), (d)(3), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 and 1989 Amendment notes.

1988—Subsec. (a). Pub. L. 100–360, § 411(*l*)(6)(B), amended Pub. L. 100–203, § 4212(b), see 1987 Amendment note below.

Pub. L. 100–360, § 411(*l*)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), added Pub. L. 100–203, § 4201(d)(4), see 1987 Amendment note below.

Pub. L. 100–360, § 411(d)(4)(A)(i), as amended by Pub. L. 100–485, § 608(d)(20)(B)(i), substituted ''most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency,'' for ''most recent certification survey conducted with respect to the agency,''.

Pub. L. 100–360, § 411(d)(4)(A)(ii)(I), as amended by Pub. L. 100–485, § 608(d)(20)(C), substituted ''such State or local agency to maintain a unit'' for ''such agency to maintain a unit''.

Pub. L. 100–360, § 411(d)(4)(A)(ii)(II), as amended by Pub. L. 100–485, § 608(d)(20)(B)(ii), substituted ''utilized by the Secretary under section 1395bb of this title'' for ''pursuant to an agreement with the Secretary under this section''.

Pub. L. 100–360, § 204(d)(3), substituted ''paragraphs (14) and (15)'' for ''paragraphs (13) and (14)''.

Pub. L. 100–360, § 204(c)(2), inserted '', or whether screening mammography meets the standards established under section 1395m(e)(3) of this title'' after ''section 1395k(a)(2)(F)(i) of this title''.

Pub. L. 100–360, § 203(e)(3), inserted ''or a home intravenous drug therapy provider,'' after ''hospice program'' and substituted ''hospice program, or home intravenous drug therapy provider'' for ''or hospice program''.

1987—Subsec. (a). Pub. L. 100–203, § 4212(b), which directed an amendment of subsec. (a) identical to Pub. L. 100–203, § 4202(c), was amended generally by Pub. L. 100–360, § 411(*l*)(6)(B), so that it does not amend this section but rather section 1396r of this title.

Pub. L. 100–203, § 4202(c), inserted '', and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),'' after ''place'' in fifth sentence.

Pub. L. 100–203, § 4201(d)(4), as added by Pub. L. 100–360, § 411(*l*)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), substituted ''conditions specified in section 1395i–3(a) of this title'' for ''conditions specified in section 1395x(j) of this title''.

Pub. L. 100–203, § 4072(d), substituted ''paragraphs (13) and (14)'' for ''paragraphs (12) and (13)'' in first sentence.

Pub. L. 100–203, § 4025(a), inserted at end ''Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted with respect to the agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency pursuant to an agreement with the Secretary under this section, and consumer medical records (but only with the consent of the consumer or his or her legal representative).''

Subsec. (d). Pub. L. 100–203, § 4203(a)(1), inserted before period at end ''and the establishment of remedies under sections 1395i–3(h)(2)(B) and 1395i–3(h)(2)(C) of this title (relating to establishment and application of remedies)''.

Pub. L. 100–203, § 4202(a)(1), inserted ''and section 1395i–3(g) of this title'' before period at end.

Pub. L. 100–203, § 4201(a)(2), added subsec. (d).

1986—Subsec. (a). Pub. L. 99–509 substituted ''paragraphs (12) and (13)'' for ''paragraphs (11) and (12)''.

1984—Subsec. (c). Pub. L. 98–369 struck out ''the'' after ''Joint Commission on''.

1982—Subsec. (a). Pub. L. 97–248 inserted ''or whether an agency is a hospice program'' and substituted ''home health agency, or hospice program'' for ''or home health agency''.

1980—Subsec. (a). Pub. L. 96–611 substituted ''requirements of paragraphs (11) and (12) of section 1395x(s) of this title'' for ''requirements of paragraphs (10) and (11) of section 1395x(s) of this title''.

Pub. L. 96–499, § 933(g), inserted ''or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title'' after ''section 1395x(aa)(2) of this title'' and ''comprehensive outpatient rehabilitation facility,'' after ''rural health clinic,'' in four places.

Pub. L. 96–499, § 934(c)(2), inserted '', or whether an ambulatory surgical center meets the standards specified under section 1395k(a)(2)(F) of this title'' after ''section 1395x(p)(4) of this title'' and ''ambulatory surgical center,'' after ''health care facility,'' in three places.

1977—Subsec. (a). Pub. L. 95–210 expanded enumeration of institutions and agencies included under coverage of this subsection by inserting references to rural health clinics in five places.

1972—Subsec. (a). Pub. L. 92–603, §§ 277, 278(a)(16), (b)(15), 299D(a), provided for the furnishing of specialized consultative services to skilled nursing facilities, authorized the Secretary to make public the pertinent findings of each survey within 90 days following the completion of each survey of any health care facility, etc., and substituted ''skilled nursing facility'' for ''extended care facility''.

Subsec. (c). Pub. L. 92–603, § 244(a), added subsec. (c).

1968—Subsec. (a). Pub. L. 90–248, § 133(f), inserted clause at end of first sentence for determining whether a clinic, rehabilitation agency, or public health agency meets the requirements of section 1395x(p)(4)(A) or (B) of this title.

Pub. L. 90–248, § 228(b), struck out last sentence providing for utilization of State facilities to provide consultative services to institutions furnishing medical care, covered in section 1396a(a)(24) of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 125(d)(2) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

Pub. L. 116–260, div. CC, title IV, § 407(a)(3)(B), Dec. 27, 2020, 134 Stat. 3008, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply with respect to agreements entered into on or after, or in effect as of, the date that is 1 year after the date of the enactment of this Act [Dec. 27, 2020].''

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Amendment by Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as a note under section 1395bb of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 145(c)(3) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4154(d)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988 [Pub. L. 100–578].''

Amendment by section 4163(c)(2) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 203(e)(3) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(c)(2), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(A), (*l*)(1)(C), (6)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4025(c), formerly § 4025(b), Dec. 22, 1987, 101 Stat. 1330–74, as redesignated and amended by Pub. L. 100–360, title IV, § 411(d)(4)(B)(i), July 1, 1988, 102 Stat. 774, provided that: ''The amendment made by this section [amending this section and section 1395bb of this title] shall apply with respect to agreements entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987].''

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendments by sections 4201(a)(2), (d)(4) and 4202(a)(1), (c) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

Amendment by section 4203(a)(1) of Pub. L. 100–203 applicable Jan. 1, 1988, except as otherwise specifically provided in section 1395i–3 of this title, without regard to whether regulations to implement such amendment are promulgated by such date, and in applying amendment by section 4203(a)(1) of Pub. L. 100–203 for services furnished by a skilled nursing facility before Oct. 1, 1990, any reference to a requirement of section 1395i–3(b), (c), or (d) of this title is deemed a reference to section 1395x(j) of this title, see section 4204(b) of Pub. L. 100–203, as added by Pub. L. 100–485, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section

122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENTS

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395*l* of this title.

For effective date of amendment by section 933(g) of Pub. L. 96–499, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 299D(c), Oct. 30, 1972, 86 Stat. 1462, provided that: ''The provisions of this section [amending this section and section 1396a of this title] shall be effective beginning January 1, 1973, or within 6 months following the enactment of this Act [Oct. 30, 1972], whichever is later.''

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 133(f) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Pub. L. 90–248, title II, § 228(b), Jan. 2, 1968, 81 Stat. 904, provided that the amendment made by such section 228(b) is effective July 1, 1969.

USE OF STATE OR LOCAL AGENCIES IN EVALUATING LABORATORIES

Pub. L. 103–432, title I, § 160(a)(2), Oct. 31, 1994, 108 Stat. 4443, provided that: ''An agreement made by the Secretary of Health and Human Services with a State under section 1864(a) of the Social Security Act [42 U.S.C. 1395aa(a)] may include an agreement that the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary for the purpose of determining whether a laboratory meets the requirements of section 353 of the Public Health Service Act [42 U.S.C. 263a].''

NURSE AID TRAINING AND COMPETENCY EVALUATION, FAILURE BY STATE TO MEET GUIDELINES

Pub. L. 101–508, title IV, § 4008(h)(1)(A), Nov. 5, 1990, 104 Stat. 1388–46, provided that: ''The Secretary of Health and Human Services may not refuse to enter into an agreement or cancel an existing agreement with a State under section 1864 of the Social Security Act [42 U.S.C. 1395aa] on the basis that the State failed to meet the requirement of section 1819(e)(1)(A) of such Act [42 U.S.C. 1395i–3(e)(1)(A)] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1819(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.''

§ 1395bb. Effect of accreditation

(a) Accreditation by American Osteopathic Association or other national accreditation body

(1) If the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or requirements of this subchapter (other than the requirements of section 1395m(j) of this title) are met or exceeded—

(A) in the case of a provider entity not described in paragraph (3)(B), the Secretary shall treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or

(B) in the case of a provider entity described in paragraph (3)(B), the Secretary may treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

(2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

(3)(A) Except as provided in subparagraph (B), not later than 60 days after the date of receipt of a written request for a finding under paragraph (1) (with any documentation necessary to make a determination on the request), the Secretary shall publish a notice identifying the national accreditation body making the request, describing the nature of the request, and providing a period of at least 30 days for the public to comment on the request. The Secretary shall approve or deny a request for such a finding, and shall publish notice of such approval or denial, not later than 210 days after the date of receipt of the request (with such documentation). Such an approval shall be effective with respect to accreditation determinations made on or after such effective date (which may not be later than the date of publication of the approval) as the Secretary specifies in the publication notice.

(B) The 210-day and 60-day deadlines specified in subparagraph (A) shall not apply in the case of any request for a finding with respect to accreditation of a provider entity to which the conditions and requirements of sections 1395i–3 and 1395x(j) of this title apply.

(4) For purposes of this section, the term ''provider entity'' means a provider of services, supplier, facility (including a renal dialysis facility), clinic, agency, or laboratory.

(b) Disclosure of accreditation survey

The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency or, beginning on December 27, 2020, a hospice program) made and released to the Secretary by the American Osteopathic Association or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(c) Deficiencies

Notwithstanding any other provision of this subchapter, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall, after the date of notice

of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the entity has been treated as meeting pursuant to subsection (a)(1).

(d) State or local accreditation

For provisions relating to validation surveys of entities that are treated as meeting applicable conditions or requirements of this subchapter pursuant to subsection (a)(1), see section 1395aa(c) of this title.

(e) Accreditation for dialysis facilities

With respect to an accreditation body that has received approval from the Secretary under subsection (a)(3)(A) for accreditation of provider entities that are required to meet the conditions and requirements under section 1395rr(b) of this title, in addition to review and oversight authorities otherwise applicable under this subchapter, the Secretary shall (as the Secretary determines appropriate) conduct, with respect to such accreditation body and provider entities, any or all of the following as frequently as is otherwise required to be conducted under this subchapter with respect to other accreditation bodies or other provider entities:

(1) Validation surveys referred to in subsection (d).

(2) Accreditation program reviews (as defined in section 488.8(c) of title 42 of the Code of Federal Regulations, or a successor regulation).

(3) Performance reviews (as defined in section 488.8(a) of title 42 of the Code of Federal Regulations, or a successor regulation).

(Aug. 14, 1935, ch. 531, title XVIII, § 1865, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 326; amended Pub. L. 92–603, title II, §§ 234(h), 244(b), Oct. 30, 1972, 86 Stat. 1413, 1423; Pub. L. 97–248, title I, §§ 122(g)(4), 128(d)(3), Sept. 3, 1982, 96 Stat. 362, 367; Pub. L. 98–369, div. B, title III, §§ 2345(a), 2346(a), July 18, 1984, 98 Stat. 1096; Pub. L. 99–509, title IX, §§ 9305(c)(3), 9320(h)(3), Oct. 21, 1986, 100 Stat. 1990, 2016; Pub. L. 100–203, title IV, §§ 4025(b), 4072(d), Dec. 22, 1987, 101 Stat. 1330–117, as amended Pub. L. 100–360, title IV, § 411(d)(4)(B)(ii), July 1, 1988, 102 Stat. 774; Pub. L. 100–360, title II, §§ 204(c)(3), (d)(3), July 1, 1988, 102 Stat. 728, 729; Pub. L. 100–485, title VI, § 608(d)(20)(D), Oct. 13, 1988, 102 Stat. 2420; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6003(g)(3)(C)(iv), 6019(a)–(c), 6115(c), Dec. 19, 1989, 103 Stat. 2153, 2165, 2166, 2219; Pub. L. 101–508, title IV, § 4163(c)(3), Nov. 5, 1990, 104 Stat. 1388–100; Pub. L. 103–432, title I, § 145(c)(4), Oct. 31, 1994, 108 Stat. 4427; Pub. L. 104–134, title I, § 101(d) [title V, § 516(b), (c)(2)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–246, 1321–247; renumbered title I, Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 108–173, title VII, § 736(a)(12), Dec. 8, 2003, 117 Stat. 2355; Pub. L. 110–275, title I, § 125(a), (b)(1), July 15, 2008, 122 Stat. 2519; Pub. L. 115–123, div. E, title IV, § 50403(a)(1), Feb. 9, 2018, 132 Stat. 217; Pub. L. 116–260, div. CC, title IV, § 407(a)(2), Dec. 27, 2020, 134 Stat. 3007.)

Editorial Notes

AMENDMENTS

2020—Subsec. (b). Pub. L. 116–260 inserted ''or, beginning on December 27, 2020, a hospice program'' after ''home health agency''.

2018—Subsec. (a)(1). Pub. L. 115–123, § 50403(a)(1)(A)(i), struck out ''or the conditions and requirements under section 1395rr(b) of this title'' after ''section 1395m(j) of this title'' in introductory provisions.

Subsec. (a)(4). Pub. L. 115–123, § 50403(a)(1)(A)(ii), inserted ''(including a renal dialysis facility)'' after ''facility''.

Subsec. (e). Pub. L. 115–123, § 50403(a)(1)(B), added subsec. (e).

2008—Subsec. (a). Pub. L. 110–275, § 125(a), redesignated subsec. (b) as (a) and struck out former subsec. (a) which provided criteria necessary for an institution to meet certain requirements enumerated in section 1395x(e) of this title.

Subsec. (a)(1). Pub. L. 110–275, § 125(b)(1)(A), substituted ''If'' for ''In addition, if''.

Subsec. (b). Pub. L. 110–275, § 125(a), (b)(1)(B), redesignated subsec. (c) as (b), substituted ''released to the Secretary by'' for ''released to him by the Joint Commission on Accreditation of Hospitals,'', and struck out the comma after ''Osteopathic Association''. Former subsec. (b) redesignated (a).

Subsecs. (c), (d). Pub. L. 110–275, § 125(a), (b)(1)(C), (D), redesignated subsecs. (d) and (e) as (c) and (d), respectively, and substituted ''pursuant to subsection (a)(1)'' for ''pursuant to subsection (a) or (b)(1)''. Former subsec. (c) redesignated (b).

Subsec. (e). Pub. L. 110–275, § 125(a), redesignated subsec. (e) as (d).

2003—Subsec. (b)(3)(B). Pub. L. 108–173 substituted ''sections'' for ''section''.

1996—Subsec. (a). Pub. L. 104–134, § 101(d) [title V, § 516(b)(2), (3)], struck out after second sentence: ''In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1395k(a)(2)(F)(i), 1395x(e), 1395x(f), 1395x(j), 1395x(*o*), 1395x(p)(4)(A) or (B), paragraphs (15) and (16) of section 1395x(s), section 1395x(aa)(2), 1395x(cc)(2), 1395x(dd)(2), or 1395x(mm)(1) of this title, as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding.'' and redesignated fourth sentence as subsec. (c).

Subsec. (b). Pub. L. 104–134, § 101(d) [title V, § 516(b)(3)], added subsec. (b). Former subsec. (b) redesignated (d).

Subsec. (c). Pub. L. 104–134, § 101(d) [title V, § 516(b)(2)], redesignated fourth sentence of subsec. (a) as subsec. (c).

Subsec. (d). Pub. L. 104–134, § 101(d) [title V, § 516(b)(1), (c)(2)(A)], redesignated subsec. (b) as (d) and substituted ''a provider entity'' for ''a hospital'', ''the entity'' for ''the hospital'' in two places, and ''the conditions or requirements the entity has been treated as meeting pursuant to subsection (a) or (b)(1) of this section'' for ''the requirements of the numbered paragraphs of section 1395x(e) of this title''.

Subsec. (e). Pub. L. 104–134, § 101(d) [title V, § 516(c)(2)(B)], added subsec. (e).

1994—Subsec. (a). Pub. L. 103–432 struck out ''1395m(c)(3),'' after ''conditions of section 1395k(a)(2)(F)(i),'' in closing provisions.

1990—Subsec. (a). Pub. L. 101–508 inserted ''1395m(c)(3),'' after ''1395k(a)(2)(F)(i),'' in second sentence.

1989—Subsec. (a). Pub. L. 101–239, § 6115(c), substituted ''paragraphs (15) and (16)'' for ''paragraphs (14) and (15)''.

Pub. L. 101–239, § 6019(b), inserted before period at end '', except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary''.

Pub. L. 101–239, §6003(g)(3)(C)(iv), substituted ''1395x(dd)(2), or 1395x(mm)(1) of this title'' for ''or 1395x(dd)(2) of this title'' in third sentence.

Pub. L. 101–234 repealed Pub. L. 100–360, §204(c)(3), (d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 and 1989 Amendment notes.

Subsec. (a)(2). Pub. L. 101–239, §6019(a), designated existing provisions as subpar. (A), struck out ''(if it is included within a survey described in section 1395aa(c) of this title)'' after ''such institution'', inserted '', together with any other information directly related to the survey as the Secretary may require (including corrective action plans)'' after ''by such Commission'', and added subpar. (B).

Subsec. (b). Pub. L. 101–239, §6019(c), struck out ''following a survey made pursuant to section 1395aa(c) of this title'' after ''if the Secretary finds''.

1988—Subsec. (a). Pub. L. 100–360, §411(d)(4)(B)(ii), as amended by Pub. L. 100–485, §608(d)(20)(D), added Pub. L. 100–203, §4025(b), see 1987 Amendment note below.

Pub. L. 100–360, §204(d)(3), substituted ''paragraphs (14) and (15)'' for ''paragraphs (13) and (14)'' in third sentence.

Pub. L. 100–360, §204(c)(3), inserted ''1395m(e)(3),'' after ''1395k(a)(2)(F)(i),'' in third sentence.

1987—Subsec. (a). Pub. L. 100–203, §4072(d), substituted ''paragraphs (13) and (14)'' for ''paragraphs (12) and (13)'' in penultimate sentence.

Pub. L. 100–203, §4025(b), as added by Pub. L. 100–360, §411(d)(4)(B)(ii), as amended by Pub. L. 100–485, §608(d)(20)(D), inserted ''(other than a survey with respect to a home health agency)'' after ''survey'' in last sentence.

1986—Subsec. (a). Pub. L. 99–509, §9305(c)(3), inserted '', requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)'' after ''the same purpose)'', and ''clause (A) or (B) of'' after ''comply also with'' in second sentence.

Pub. L. 99–509, §9320(h)(3), substituted ''paragraphs (12) and (13)'' for ''paragraphs (11) and (12)'' in third sentence.

1984—Subsec. (a). Pub. L. 98–369, §2346(a), in provisions following par. (4), substituted ''section 1395k(a)(2)(F)(i), 1395x(e), 1395x(f), 1395x(j), 1395x(*o*), 1395x(p)(4)(A) or (B), paragraphs (11) and (12) of section 1395x(s), section 1395x(aa)(2), 1395x(cc)(2), or 1395x(dd)(2) of this title'' for ''section 1395x(e), (j), (*o*), or (dd) of this title'', and substituted ''entity'' for ''institution or agency'' in two places.

Pub. L. 98–369, §2345(a), struck out ''(on a confidential basis)'' after ''release to the Secretary'' in par. (2), and inserted provision that the Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body, in provisions following par. (4).

1982—Subsec. (a). Pub. L. 97–248, §122(g)(4), substituted ''(*o*), or (dd)'' for ''or (*o*)''.

Subsec. (b). Pub. L. 97–248, §128(d)(3), substituted ''a hospital'' for ''an institution'' and ''the hospital'' for ''such institution''.

1972—Pub. L. 92–603 designated existing provisions as subsec. (a), inserted reference to subsec. (b) of this section in opening provisions, redesignated existing provisions as pars. (1) and (3) and added pars. (2) and (4) and in provisions following par. (4) inserted provisions for the imposition of a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in par. (4), and added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Pub. L. 110–275, title I, §125(d), July 15, 2008, 122 Stat. 2520, provided that:

''(1) Subject to paragraph (2), the amendments made by this section [amending this section and sections 1395m, 1395w–22, 1395x, 1395aa, and 1395*ll* of this title] shall apply with respect to accreditations of hospitals granted on or after the date that is 24 months after the date of the enactment of this Act [July 15, 2008].

''(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect [sic] the accreditation of a hospital by the Joint Commission, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission, for the period of time applicable under such accreditation.''

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6019(d), Dec. 19, 1989, 103 Stat. 2166, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].

''(2) The amendments made by subsection (a) [amending this section] shall take effect 6 months after the date of the enactment of this Act.''

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(c)(3), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(B)(ii) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4025(b) of Pub. L. 100–203 applicable with respect to agreements entered into or renewed on or after Dec. 22, 1987, see section 4025(c) of Pub. L. 100–203, as amended, set out as a note under section 1395aa of this title.

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9305(c)(3) of Pub. L. 99–509 applicable to hospitals as of one year after Oct. 21, 1986,

see section 9305(c)(4) of Pub. L. 99–509, set out as a note under section 1395x of this title.

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2345(b), July 18, 1984, 98 Stat. 1096, provided that: ''The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984], and shall apply with respect to surveys released to the Secretary on, before, or after such date.''

Pub. L. 98–369, div. B, title III, § 2346(b), July 18, 1984, 98 Stat. 1096, provided that: ''The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984].''

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(g)(4) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(d)(3) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 234(h) of Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after the fifth month following October 1972, see section 234(i) of Pub. L. 92–603, set out as a note under section 1395x of this title.

TIMING FOR ACCEPTANCE OF REQUESTS FROM ACCREDITATION ORGANIZATIONS

Pub. L. 115–123, div. E, title IV, § 50403(a)(2), Feb. 9, 2018, 132 Stat. 218, provided that: ''Not later than 90 days after the date of enactment of this Act [Feb. 9, 2018], the Secretary of Health and Human Services shall begin accepting requests from national accreditation bodies for a finding described in section 1865(a)(3)(A) of the Social Security Act (42 U.S.C. 1395bb(a)(3)(A)) for purposes of accrediting provider entities that are required to meet the conditions and requirements under section 1881(b) of such Act (42 U.S.C. 1395rr(b)).''

AUTHORITY TO RECOGNIZE THE JOINT COMMISSION AS A NATIONAL ACCREDITATION BODY

Pub. L. 110–275, title I, § 125(c), July 15, 2008, 122 Stat. 2519, provided that: ''The Secretary of Health and Human Services may recognize the Joint Commission as a national accreditation body under section 1865 of the Social Security Act (42 U.S.C. 1395bb), as amended by this section, upon such terms and conditions, and upon submission of such information, as the Secretary may require.''

§ 1395cc. Agreements with providers of services; enrollment processes

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care pro-

vided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, rural emergency hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H)(i) in the case of hospitals which provide services for which payment may be made under this subchapter and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this subchapter,

to have items and services (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the skilled nursing facility,

(I) in the case of a hospital, critical access hospital, or rural emergency hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital, critical access hospital, or rural emergency hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 1713[1] of title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10,

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under chapter 17 of title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

[1] See References in Text note below.

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals, critical access hospitals, and rural emergency hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital, critical access hospital, or rural emergency hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital, critical access hospital, or rural emergency hospital participates in the medicaid program under a State plan approved under subchapter XIX,

(O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1395eee or 1396u–4 of this title, or with an eligible organization with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b–1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(ii) of this title, or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1395ww(d)(12) of this title to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 1603 of title 25), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 1603),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,[2]

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and

[2] So in original. The comma probably should be preceded by a closing parenthesis.

Health Act of 1970 [29 U.S.C. 651 et seq.] (or a State occupational safety and health plan that is approved under 18(b)[3] of such Act [29 U.S.C. 667(b)]), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

(W) in the case of a hospital described in section 1395ww(d)(1)(B)(v) of this title, to report quality data to the Secretary in accordance with subsection (k),

(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this subchapter, as specified by the Secretary, and

(Y) beginning 12 months after August 6, 2015, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395*l*(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395*l*(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10)(A) of this title and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395*l*(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B under the prospective payment system established under section 1395*l*(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395*l*(t)(5)[1] of this title. In the case of services described in section 1395*l*(a)(8) of this title or section 1395*l*(a)(9) of this title for which payment is made under part B under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or serv-

[3] So in original. Probably should be preceded by ''section''.

ices which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c–3(a)(4)(A) of this title and under section 1320c–3(a)(14) of this title with respect to services, furnished by the hospital, critical access hospital, rural emergency hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, rural emergency hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, rural emergency hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, rural emergency hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, rural emergency hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, rural emergency hospitals, or agencies under part B of subchapter XI.

(b) Termination or nonrenewal of agreements

(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a–7 of this title or section 1320a–7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a–7(c) of this title.

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to

the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 [29 U.S.C. 666] for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U)[4] by a hospital that is subject to the provisions of such Act [29 U.S.C. 651 et seq.].

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(c) Refiling after termination or nonrenewal; agreements with skilled nursing facilities

(1) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under subchapter XIX of such termination or nonrenewal.

(d) Decision to withhold payment for failure to review long-stay cases

If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(k) of this title of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) "Provider of services" defined

For purposes of this section, the term ''provider of services'' shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (*ll*)(2) of section 1395x of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1395x(*ll*)(2) of this title) with respect to the furnishing of outpatient speech-language pathology;

(2) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(ff)(1) of this title); and

(3) opioid treatment programs (as defined in paragraph (2) of section 1395x(jjj) of this title), but only with respect to the furnishing of opioid use disorder treatment services (as defined in paragraph (1) of such section).

(f) Maintenance of written policies and procedures

(1) For purposes of subsection (a)(1)(Q) and sections 1395i–3(c)(2)(E),[5] 1395*l*(s), 1395w–25(i), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

[4] So in original. Probably should be subsection ''(a)(1)(V)''.

[5] So in original. Probably should refer to section 1395i–3(c)(1)(E).

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395*l*(a)(1)(A) of this title or a Medicare+ Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term ''advance directive'' means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Penalties for improper billing

Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1395ff(b)(2) of this title. Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i–3 of this title during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1395i–3(h)(2)(B) of this title has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i–3 of this title during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1320a–7 of this title and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i) Intermediate sanctions for psychiatric hospitals

(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this subchapter and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with

such requirements, no payment may be made under this subchapter with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this subchapter.

(j) Enrollment process for providers of services and suppliers

(1) Enrollment process

(A) In general

The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this subchapter. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) Deadlines

The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) Consultation before changing provider enrollment forms

The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this subchapter.

(2) Provider screening

(A) Procedures

Not later than 180 days after March 23, 2010, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this subchapter, the Medicaid program under subchapter XIX, and the CHIP program under subchapter XXI.

(B) Level of screening

The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a licensure check, which may include such checks across States; and

(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

(I) a criminal background check;

(II) fingerprinting;

(III) unscheduled and unannounced site visits, including preenrollment site visits;

(IV) database checks (including such checks across States); and

(V) such other screening as the Secretary determines appropriate.

(C) Application fees

(i) Institutional providers

Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(I) for 2010, $500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) Hardship exception; waiver for certain Medicaid providers

The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) Use of funds

Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1320a–7k of this title.

(D) Application and enforcement

(i) New providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of March 23, 2010, on or after the date that is 1 year after such date.

(ii) Current providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of such date, on or after the date that is 2 years after such date.

(iii) Revalidation of enrollment

Effective beginning on the date that is 180 days after such date, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this subchapter, subchapter XIX, or subchapter XXI.

(iv) Limitation on enrollment and revalidation of enrollment

In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 3 years after such date.

(E) Use of information from the Department of Treasury concerning tax debts

In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this subchapter, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(*l*)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) Expedited rulemaking

The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) Provisional period of enhanced oversight for new providers of services and suppliers

(A) In general

The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this subchapter, the Medicaid program under subchapter XIX.[6] and the CHIP program under subchapter XXI.

(B) Implementation

The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-day period of enhanced oversight for initial claims of DME suppliers

For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under this subchapter identified pursuant to such determination and who is initially enrolling under such subchapter, the Secretary shall, notwithstanding sections 1395h(c), 1395u(c), and 1395ff(a)(2) of this title, withhold payment under such subchapter with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such subchapter for durable medical equipment furnished by such supplier.

(5) Increased disclosure requirements

(A) Disclosure

A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 1 year after March 23, 2010, shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1320a–7b(f) of this title), has been excluded from participation under the program under this subchapter, the Medicaid program under subchapter XIX, or the CHIP program under subchapter XXI, or has had its billing privileges denied or revoked.

(B) Authority to deny enrollment

If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) Authority to adjust payments of providers of services and suppliers with the same tax identification number for medicare obligations

(A) In general

Notwithstanding any other provision of this subchapter, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this subchapter in order to satisfy any amount described in subparagraph (B)(ii) due from such obligated provider of services or supplier.

(B) Definitions

In this paragraph:

(i) In general

The term ''applicable provider of services or supplier'' means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number

[6] So in original. Probably should be a comma.

under the program under this subchapter than is assigned to the obligated provider of services or supplier.

(ii) Obligated provider of services or supplier

The term ''obligated provider of services or supplier'' means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this subchapter (as determined by the Secretary).

(7) Temporary moratorium on enrollment of new providers; nonpayment

(A) In general

The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this subchapter, under the Medicaid program under subchapter XIX, or under the CHIP program under subchapter XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) Limitation on review

There shall be no judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) Nonpayment

(i) In general

No payment may be made under this subchapter or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) Item or service described

An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) Requirements

For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

(I) enrolls under this subchapter on or after the effective date of such temporary moratorium; and

(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

(iv) Prohibition on charges for specified items or services

In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).

(8) Hearing rights in cases of denial or non-renewal

A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this subchapter is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

(9) Compliance programs

(A) In general

On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) Establishment of core elements

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) Timeline for implementation

The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(k) Quality reporting by cancer hospitals

(1) In general

For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1395ww(d)(1)(B)(v) of this title shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) Submission of quality data

For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) Quality measures

(A) In general

Subject to subparagraph (B), any measure specified by the Secretary under this para-

graph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1395ww(d)(1)(B)(v) of this title has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 327; amended Pub. L. 90–248, title I, §§ 129(c)(12), 133(c), 135(b), Jan. 2, 1968, 81 Stat. 849, 851, 852; Pub. L. 92–603, title II, §§ 223(e), (g), 227(d)(2), 229(b), 249A(b)–(d), 278(a)(17), (b)(18), 281(c), Oct. 30, 1972, 86 Stat. 1394, 1406, 1409, 1427, 1453–1455; Pub. L. 95–142, §§ 3(b), 8(b), 13(b)(3), 15(a), Oct. 25, 1977, 91 Stat. 1178, 1194, 1195, 1198, 1200; Pub. L. 95–210, § 2(e), Dec. 13, 1977, 91 Stat. 1489; Pub. L. 95–292, § 4(e), June 13, 1978, 92 Stat. 315; Pub. L. 96–272, title III, § 308(b), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, § 916(a), Dec. 5, 1980, 94 Stat. 2623; Pub. L. 96–611, § 1(b)(4), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, § 2153, Aug. 13, 1981, 95 Stat. 802; Pub. L. 97–248, title I, §§ 122(g)(5), (6), 128(a)(5), (d)(4), 144, Sept. 3, 1982, 96 Stat. 362, 366, 367, 393; Pub. L. 97–448, title III, § 309(a)(5), (b)(11), Jan. 12, 1983, 96 Stat. 2408, 2409; Pub. L. 98–21, title VI, § 602(f), (*l*), Apr. 20, 1983, 97 Stat. 163, 166; Pub. L. 98–369, div. B, title III, §§ 2303(f), 2315(d), 2321(c), 2323(b)(3), 2335(d), 2347(a), 2348(a), 2354(b)(33), (34), July 18, 1984, 98 Stat. 1066, 1080, 1084, 1086, 1090, 1096, 1097, 1102; Pub. L. 99–272, title IX, §§ 9121(a), 9122(a), 9401(b)(2)(F), 9402(a), 9403(b), Apr. 7, 1986, 100 Stat. 164, 167, 199, 200; Pub. L. 99–509, title IX, §§ 9305(b)(1), 9320(h)(2), 9332(e)(1), 9337(c)(2), 9343(c)(2), (3), 9353(e)(1), Oct. 21, 1986, 100 Stat. 1989, 2016, 2025, 2034, 2040, 2047; Pub. L. 99–514, title XVIII, § 1895(b)(5), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 99–576, title II, § 233(a), Oct. 28, 1986, 100 Stat. 3265; Pub. L. 100–93, § 8(d), Aug. 18, 1987, 101 Stat. 693; Pub. L. 100–203, title IV, §§ 4012(a), 4062(d)(4), 4085(i)(17), (28), 4097(a), (b), 4212(e)(4), Dec. 22, 1987, 101 Stat. 1330–60, 1330–109, 1330–133, 1330–140, 1330–213, as amended Pub. L. 100–360, title IV, § 411(i)(4)(C)(vi), (j)(5), July 1, 1988, 102 Stat. 790, 791; Pub. L. 100–360, title I, § 104(d)(5), title II, §§ 201(b), (d), 202(h)(1), title IV, § 411(c)(2)(A)(i), (C), (g)(1)(D), July 1, 1988, 102 Stat. 689, 702, 718, 772, 782, as amended Pub. L. 100–485, title VI, § 608(d)(3)(F), (19)(A), Oct. 13, 1988, 102 Stat. 2414, 2419; Pub. L. 100–485, title VI, § 608(f)(1), Oct. 13, 1988, 102 Stat. 2424; Pub. L. 101–234, title I, § 101(a), title II, § 201(a), title III, § 301(b)(4), (d)(1), Dec. 13, 1989, 103 Stat. 1979, 1981, 1985, 1986; Pub. L. 101–239, title VI, §§ 6003(g)(3)(D)(xii), (xiii), 6017, 6018(a), 6020, 6112(e)(3), Dec. 19, 1989, 103 Stat. 2154, 2165, 2166, 2216; Pub. L. 101–508, title IV, §§ 4008(b)(3)(B), (m)(3)(G)[(F)], 4153(d)(1), 4157(c)(2), 4162(b)(2), 4206(a), Nov. 5, 1990, 104 Stat. 1388–44, 1388–54, 1388–84, 1388–89, 1388–96, 1388–115; Pub. L. 102–54, § 13(q)(3)(F), June 13, 1991, 105 Stat. 280; Pub. L. 102–83, § 5(c)(2), Aug. 6, 1991, 105 Stat. 406; Pub. L. 103–296, title I, § 108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 103–432, title I, §§ 106(b)(1)(B), 147(e)(7), 156(a)(2)(E), 160(d)(2), Oct. 31, 1994, 108 Stat. 4406, 4430, 4441, 4443; Pub. L. 104–191, title II, § 262(b)(1), Aug. 21, 1996, 110 Stat. 2031; Pub. L. 105–12, § 9(a)(2), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§ 4002(d), (e), 4201(c)(1), 4302(a), 4321(b), 4432(b)(5)(F), 4511(a)(2)(D), 4523(b), 4541(a)(3), 4641(a), 4714(b)(1), Aug. 5, 1997, 111 Stat. 329, 373, 382, 395, 422, 442, 449, 456, 487, 510; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(k)(11), (12)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368; Pub. L. 106–554, § 1(a)(6) [title III, § 313(b)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499; Pub. L. 108–173, title II, § 236(a)(1), title V, §§ 505(b), 506(a), title VII, § 736(a)(13), title IX, §§ 932(b), (c)(1), 936(a), 947(a), Dec. 8, 2003, 117 Stat. 2210, 2294, 2355, 2400, 2401, 2411, 2425; Pub. L. 110–275, title I, § 143(b)(8), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title III, § 3005, title VI, §§ 6401(a), 6406(b), title X, § 10603, Mar. 23, 2010, 124 Stat. 371, 747, 769, 1006; Pub. L. 111–152, title I, § 1304, Mar. 30, 2010, 124 Stat. 1058; Pub. L. 111–192, title I, § 103(b), (c), June 25, 2010, 124 Stat. 1283; Pub. L. 112–40, title II, § 261(a)(3)(A), (D), Oct. 21, 2011, 125 Stat. 423; Pub. L. 114–42, § 2, Aug. 6, 2015, 129 Stat. 468; Pub. L. 114–255, div. C, title XVII, § 17004(a), (b)(2)(A), Dec. 13, 2016, 130 Stat. 1331, 1333; Pub. L. 115–182, title I, § 144(a)(2), June 6, 2018, 132 Stat. 1430; Pub. L. 115–271, title II, § 2005(d), Oct. 24, 2018, 132 Stat. 3930; Pub. L. 116–260, div. CC, title I, § 125(b)(1), (2)(A), Dec. 27, 2020, 134 Stat. 2965.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(b)(1), (2)(A) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Section 1713 of title 38, referred to in subsec. (a)(1)(J), was renumbered section 1781 of title 38 by Pub. L. 107–135, title II, § 208(c)(1), (2), Jan. 23, 2002, 115 Stat. 2463.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(O), is section 222(a) of Pub. L. 92–603, which is set out as a note under section 1395b–1 of this title.

The Occupational Safety and Health Act of 1970, referred to in subsecs. (a)(1)(V) and (b)(4)(B), is Pub. L. 91–596, Dec. 29, 1970, 84 Stat. 1590, as amended, which is classified principally to chapter 15 (§ 651 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 651 of Title 29 and Tables.

Section 1395*l*(t)(5) of this title, referred to in subsec. (a)(2)(A), was redesignated section 1395*l*(t)(8) of this title by Pub. L. 106–113, div. B, § 1000(a)(6) [title II, §§ 201(a)(1), 202(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336, 1501A–342.

The Internal Revenue Code of 1986, referred to in subsec. (j)(2)(E), (6)(B)(i), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2020—Subsec. (a)(1)(F)(ii). Pub. L. 116–260, § 125(b)(1)(A), inserted ''rural emergency hospitals,'' after ''critical access hospitals,''.

Subsec. (a)(1)(I). Pub. L. 116–260, § 125(b)(2)(A)(i)(I), substituted '', critical access hospital, or rural emergency hospital'' for ''or critical access hospital'' in introductory provisions.

Subsec. (a)(1)(I)(ii). Pub. L. 116–260, § 125(b)(2)(A)(i)(II), inserted '', critical access hospital, or rural emergency hospital'' after ''hospital''.

Subsec. (a)(1)(N). Pub. L. 116–260, § 125(b)(2)(A)(ii)(I), substituted '', critical access hospitals, and rural emergency hospitals'' for ''and critical access hospitals'' in introductory provisions.

Subsec. (a)(1)(N)(i). Pub. L. 116–260, § 125(b)(2)(A)(ii)(II), substituted '', critical access hospital, or rural emergency hospital'' for ''or critical access hospital''.

Subsec. (a)(1)(N)(iv). Pub. L. 116–260, § 125(b)(2)(A)(ii)(III), inserted '', critical access hospital, or rural emergency hospital'' after ''hospital''.

Subsec. (a)(3)(A). Pub. L. 116–260, § 125(b)(1)(B)(i), inserted ''rural emergency hospital,'' after ''critical access hospital,''.

Subsec. (a)(3)(B). Pub. L. 116–260, § 125(b)(1)(B)(ii), inserted ''rural emergency hospital,'' after ''critical access hospital,'' wherever appearing.

Subsec. (a)(3)(C)(ii)(II). Pub. L. 116–260, § 125(b)(1)(B)(iii), inserted ''rural emergency hospitals,'' after ''critical access hospitals,'' in two places.

2018—Subsec. (a)(1)(L). Pub. L. 115–182 substituted ''under chapter 17'' for ''under section 603''. Amendment was executed by making the substitution for ''under section 1703'', which appeared in text after the substitution of ''section 1703'' for ''section 603'' pursuant to Pub. L. 102–83. See 1991 Amendment note below.

Subsec. (e)(3). Pub. L. 115–271 added par. (3).

2016—Subsec. (j)(1)(A). Pub. L. 114–255, § 17004(b)(2)(A)(i), substituted ''requirements in accordance with paragraph (5)'' for ''requirements in accordance with paragraph (4)'', ''moratoria in accordance with paragraph (7)'' for ''moratoria in accordance with paragraph (5)'', and ''paragraph (9)'' for ''paragraph (6)''.

Subsec. (j)(7). Pub. L. 114–255, § 17004(a)(1), in heading, inserted ''; nonpayment'' at end.

Subsec. (j)(7)(C). Pub. L. 114–255, § 17004(a)(2), added subpar. (C).

Subsec. (j)(8), (9). Pub. L. 114–255, § 17004(b)(2)(A)(ii), redesignated par. (8), relating to compliance programs, as (9).

2015—Subsec. (a)(1)(W), (X). Pub. L. 114–42, § 2(1)–(3)(A), redesignated subpar. (W), relating to maintaining and providing access to documentation, as (X).

Subsec. (a)(1)(Y). Pub. L. 114–42, § 2(3)(B), (4), added subpar. (Y).

2011—Subsec. (a)(1)(F). Pub. L. 112–40, § 261(a)(3)(A), substituted ''quality improvement'' for ''utilization and quality control peer review'' in cls. (i) and (ii).

Subsec. (a)(3). Pub. L. 112–40, § 261(a)(3)(D), substituted ''quality improvement'' for ''peer review'' in subpars. (A) and (B).

2010—Subsec. (a)(1)(U). Pub. L. 111–148, § 6406(b)(1), which directed amendment by striking out ''and'' at end, could not be executed because of the intervening amendment by Pub. L. 111–148, § 3005(1)(A). See Amendment note below.

Pub. L. 111–148, § 3005(1)(A), struck out ''and'' after ''services,'' in concluding provisions.

Subsec. (a)(1)(V). Pub. L. 111–148, § 6406(b)(2), which directed amendment by substituting ''; and'' for period at end, could not be executed because of the intervening amendment by Pub. L. 111–148, § 3005(1)(B). See Amendment note below.

Pub. L. 111–148, § 3005(1)(B), substituted '', and'' for period at end.

Subsec. (a)(1)(W). Pub. L. 111–148, § 6406(b)(3), added subpar. (W) relating to maintaining and providing access to documentation. Subpar. (W) was added after subpar. (W) relating to reporting quality data to the Secretary to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Pub. L. 111–148, § 3005(1)(C), added subpar. (W) relating to reporting quality data to the Secretary. Subpar. (W) was added after subpar. (V) to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Subsec. (j)(1)(A). Pub. L. 111–148, § 6401(a)(1), inserted at end ''Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).''

Subsec. (j)(2). Pub. L. 111–148, § 6401(a)(3), added par. (2). Former par. (2) redesignated (8).

Subsec. (j)(2)(C). Pub. L. 111–148, § 10603(a), redesignated cls. (ii) to (iv) as (i) to (iii), respectively, substituted ''clause (ii)'' for ''clause (iii)'' in cl. (i), and struck out former cl. (i) which read as follows: ''Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

''(I) for 2010, $200; and

''(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.''

Subsec. (j)(2)(E), (F). Pub. L. 111–192, § 103(b), added subpar. (E) and redesignated former subpar. (E) as (F).

Subsec. (j)(3). Pub. L. 111–148, § 6401(a)(3), added par. (3).

Subsec. (j)(4), (5). Pub. L. 111–152, § 1304, added par. (4) and redesignated former par. (4) as (5). Former par. (5) redesignated (6).

Pub. L. 111–148, § 6401(a)(3), added pars. (4) and (5).

Subsec. (j)(6). Pub. L. 111–192, § 103(c)(1), substituted ''medicare'' for ''past-due'' in heading.

Pub. L. 111–152, § 1304(1), redesignated par. (5) as (6). Former par. (6) redesignated (7).

Pub. L. 111–148, § 6401(a)(3), added par. (6).

Subsec. (j)(6)(A). Pub. L. 111–192, § 103(c)(2), substituted ''amount described in subparagraph (B)(ii) due from such'' for ''past-due obligations described in subparagraph (B)(ii) of an''.

Subsec. (j)(6)(B)(ii). Pub. L. 111–192, § 103(c)(3), substituted ''an amount that is more than the amount required to be paid'' for ''a past-due obligation''.

Subsec. (j)(7). Pub. L. 111–152, § 1304(1), redesignated par. (6) as (7). Former par. (7) redesignated (8).

Pub. L. 111–148, § 6401(a)(3), added par. (7).

Subsec. (j)(8). Pub. L. 111–152, § 1304(1), redesignated par. (7) as (8) relating to compliance programs.

Pub. L. 111–148, § 6401(a)(2), as amended by Pub. L. 111–148, § 10603(b), redesignated par. (2) as (8).

Subsec. (k). Pub. L. 111–148, § 3005(2), added subsec. (k).

2008—Subsec. (e)(1). Pub. L. 110–275 substituted ''section through the operation of subsection (g) or (*ll*)(2) of section 1395x'' for ''section through the operation of section 1395x(g)'' in two places, substituted ''defined),'' for ''defined) or'', and inserted '', or (through the operation of section 1395x(*ll*)(2) of this title) with respect to the furnishing of outpatient speech-language pathology'' before ''; and''.

2003—Pub. L. 108–173, §936(a)(1), inserted ''; enrollment processes'' in section catchline.

Subsec. (a)(1)(O). Pub. L. 108–173, §236(a)(1), substituted ''part C, with a PACE provider under section 1395eee or 1396u–4 of this title, or'' for ''part C or'', struck out ''(i)'' before ''with a risk-sharing contract'', struck out ''and (ii)'' before ''which does not have a contract'', inserted ''(or, in the case of a PACE provider, contract or other agreement)'' after ''have a contract'', and substituted ''members of the organization or PACE program eligible individuals enrolled with the PACE provider,'' for ''members of the organization''.

Subsec. (a)(1)(T). Pub. L. 108–173, §505(b), added subpar. (T).

Subsec. (a)(1)(U). Pub. L. 108–173, §506(a), added subpar. (U).

Subsec. (a)(1)(V). Pub. L. 108–173, §947(a)(1), added subpar. (V).

Subsec. (b)(2)(D). Pub. L. 108–173, §736(a)(13), realigned margins.

Subsec. (b)(4). Pub. L. 108–173, §947(a)(2), added par. (4).

Subsec. (h)(1). Pub. L. 108–173, §932(b), (c)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j). Pub. L. 108–173, §936(a)(2), added subsec. (j).

2000—Subsec. (a)(1)(H)(ii)(I). Pub. L. 106–554 inserted ''during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period)'' after ''skilled nursing facility''.

1999—Subsec. (a)(1)(I)(iii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(A)], substituted comma for semicolon at end.

Subsec. (a)(1)(N)(iv). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(B)], struck out ''and'' at end.

Subsec. (a)(1)(O). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(C)], substituted comma for semicolon at end.

Subsec. (a)(1)(Q). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(12)(A)], substituted comma for semicolon at end.

Subsec. (a)(1)(R). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(12)(B)], inserted '', and'' at end.

1997—Subsec. (a)(1)(A). Pub. L. 105–33, §4714(b)(1), designated existing provisions as cl. (i) and inserted before comma at end '', and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title''.

Subsec. (a)(1)(F)(ii). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (a)(1)(H). Pub. L. 105–33, §4511(a)(2)(D), substituted ''section 1395x(s)(2)(K) of this title'' for ''section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title''.

Pub. L. 105–33, §4432(b)(5)(F), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' in two places.

Subsec. (a)(1)(I), (N). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' in introductory provisions of subpars. (I) and (N) and in subpar. (N)(i).

Subsec. (a)(1)(O). Pub. L. 105–33, §4002(e), struck out ''in the case of hospitals and skilled nursing facilities,'' before ''to accept as payment in full for'', ''inpatient hospital and extended care'' after ''to accept as payment in full for'', and ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)'' after ''the organization the amounts''; inserted ''with a Medicare+Choice organization under part C or'' after ''any individual enrolled'' and ''(less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title)'' after ''under this subchapter''.

Subsec. (a)(1)(S). Pub. L. 105–33, §4321(b), added subpar. (S). Subpar. (S) was added after subpar. (R) to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Subsec. (a)(2)(A). Pub. L. 105–33, §4541(a)(3), which directed the amendment of subsec. (a)(2)(A)(ii) by inserting the following at the end ''In the case of services described in section 1395*l*(a)(8) of this title or section 1395*l*(a)(9) of this title for which payment is made under part B under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.'', was executed by inserting the material at the end of subpar. (A) to reflect the probable intent of Congress.

Pub. L. 105–33, §4523(b), which directed the amendment of subsec. (a)(2)(A)(ii) by inserting the following at the end ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1395*l*(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395*l*(t)(5) of this title.'', was executed by inserting the material at the end of subpar. (A) to reflect the probable intent of Congress.

Subsec. (a)(3). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care'' wherever appearing.

Subsec. (b)(2)(D). Pub. L. 105–33, §4302(a), added subpar. (D).

Subsec. (f)(1). Pub. L. 105–33, §4002(d)(1), inserted ''1395w–25(i),'' after ''1395*l*(s),'' and '', Medicare+Choice organization,'' after ''provider of services'' in introductory provisions.

Subsec. (f)(1)(B). Pub. L. 105–33, §4641(a), substituted ''in a prominent part of the individual's current medical record'' for ''in the individual's medical record''.

Subsec. (f)(2)(E). Pub. L. 105–33, §4002(d)(2), inserted ''or a Medicare+Choice organization'' after ''section 1395*l*(a)(1)(A) of this title''.

Subsec. (f)(4). Pub. L. 105–12 added par. (4).

1996—Subsec. (a)(1)(R). Pub. L. 104–191 added subpar. (R).

1994—Subsec. (a)(1)(H). Pub. L. 103–432, §147(e)(7), substituted ''section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title'' for ''section 1395x(s)(2)(K)(i) of this title''.

Subsec. (a)(2)(A). Pub. L. 103–432, §156(a)(2)(E), struck out '', with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),'' after ''section 1395x(s)(10)(A) of this title''.

Subsec. (d). Pub. L. 103–432, §106(b)(1)(B), substituted ''long-stay cases in a hospital'' for ''long-stay cases in a hospital or skilled nursing facility'', ''such hospital'' for ''such hospital or facility'' in two places, ''period of such services'' for ''period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be'', and ''notice to the hospital'' for ''notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement,''.

Subsec. (f)(1). Pub. L. 103–432, §160(d)(2), substituted ''1395*l*(s)'' for ''1395*l*(r)'' in introductory provisions.

Subsec. (h)(1). Pub. L. 103–296 inserted before period at end '', except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively''.

1991—Subsec. (a)(1)(J). Pub. L. 102–83 substituted ''section 1713 of title 38'' for ''section 613 of title 38''.

Subsec. (a)(1)(L). Pub. L. 102–83 substituted ''section 1703 of title 38'' for ''section 603 of title 38''.

Pub. L. 102–54 substituted ''Secretary of Veterans Affairs'' for ''Administrator of Veterans' Affairs''.

1990—Subsec. (a)(1)(F)(i). Pub. L. 101–508, §4008(m)(3)(G)[(F)](i), substituted '')'' for comma at end.

Subsec. (a)(1)(F)(ii). Pub. L. 101–508, §4008(m)(3)(G)[(F)](ii), substituted ''paragraph (3)(A),'' for ''paragraph (4)(A);''.

Subsec. (a)(1)(H). Pub. L. 101–508, §4157(c)(2), inserted ''services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and'' after ''and other than''.

Subsec. (a)(1)(I)(i). Pub. L. 101–508, §4008(b)(3)(B), inserted ''and to meet the requirements of such section'' after ''section 1395dd of this title''.

Subsec. (a)(1)(P). Pub. L. 101–508, §4153(d)(1), substituted ''catheters, catheter supplies, ostomy bags, and supplies related to ostomy care'' for ''ostomy supplies''.

Subsec. (a)(1)(Q). Pub. L. 101–508, §4206(a)(1), added subpar. (Q).

Subsec. (e). Pub. L. 101–508, §4162(b)(2), substituted ''include—'' and pars. (1) and (2) for ''include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of section 1395x(g) of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of section 1395x(g) of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services.''

Subsec. (f). Pub. L. 101–508, §4206(a)(2), added subsec. (f).

1989—Subsec. (a)(1)(F)(i)(III). Pub. L. 101–234, §301(b)(4), (d)(1), amended subcl. (III) identically substituting ''fiscal year)'' for ''fiscal year))'' before ''of such reviews,'' at end.

Subsec. (a)(1)(F)(ii). Pub. L. 101–239, §6003(g)(3)(D)(xii)(I), inserted ''rural primary care hospitals,'' after ''hospitals,''.

Subsec. (a)(1)(H). Pub. L. 101–239, §6003(g)(3)(D)(xii)(II), inserted ''and in the case of rural primary care hospitals which provide rural primary care hospital services'' after ''payment may be made under this subchapter''.

Subsec. (a)(1)(I). Pub. L. 101–239, §6018(a)(1), amended subpar. (I) generally. Prior to amendment, subpar. (I) read as follows: ''in the case of a hospital and in the case of a rural primary care hospital, to comply with the requirements of section 1395dd of this title to the extent applicable,''.

Pub. L. 101–239, §6003(g)(3)(D)(xii)(III), inserted ''and in the case of a rural primary care hospital'' after ''hospital''.

Subsec. (a)(1)(N). Pub. L. 101–239, §6003(g)(3)(D)(xii)(IV), substituted ''hospitals and rural primary care hospitals'' for ''hospitals'' in introductory provisions and ''hospital or rural primary care hospital,'' for ''hospital,'' in cl. (i).

Subsec. (a)(1)(N)(iii), (iv). Pub. L. 101–239, §6018(a)(2), added cls. (iii) and (iv).

Subsec. (a)(1)(P). Pub. L. 101–239, §6112(e)(3), added subpar. (P).

Subsec. (a)(2)(A). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§201(b), (d), 202(h)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(2)(B). Pub. L. 101–239, §6017, redesignated cl. (i) as subpar. (B) and struck out cl. (ii) which authorized charges for items or services more expensive than determined to be necessary and which have not been requested by the individual to the extent that such costs in the second fiscal period preceding the fiscal period in which such charges are imposed exceed necessary costs, under certain circumstances.

Subsec. (a)(3)(A), (B). Pub. L. 101–239, §6003(g)(3)(D)(xiii)(I), substituted ''hospital, rural primary care hospital,'' for ''hospital,'' wherever appearing.

Subsec. (a)(3)(C)(ii)(II). Pub. L. 101–239, §6003(g)(3)(D)(xiii)(II), substituted ''facilities, rural primary care hospitals,'' for ''facilities'' in two places.

Subsec. (d). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(5), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i). Pub. L. 101–239, §6020, added subsec. (i).

1988—Subsec. (a)(1)(M). Pub. L. 100–360, §411(c)(2)(C)(i), as added by Pub. L. 100–485, §608(d)(19)(A), struck out ''and'' at end.

Subsec. (a)(1)(N). Pub. L. 100–360, §411(c)(2)(C)(ii), as added by Pub. L. 100–485, §608(d)(19)(A), substituted '', and'' for period at end.

Subsec. (a)(1)(O). Pub. L. 100–360, §411(c)(2)(A)(i), substituted cls. (i) and (ii) for ''with a risk-sharing contract under section 1395mm of this title''.

Subsec. (a)(2)(A). Pub. L. 100–360, §201(d), substituted ''section 1395*l*(d)(1) of this title'' for ''section 1395*l*(c) of this title'' in second sentence.

Pub. L. 100–360, §411(g)(1)(D), substituted ''section 1395m(a)(1)(B) of this title'' for ''section 1395m(a)(2) of this title'' in last sentence.

Pub. L. 100–360, §202(h)(1), inserted ''1395m(c),'' after ''1395*l*(b),'' and ''and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1395m(c)(2)(C) of this title) of the lesser of the actual charges for the drugs or the payment limit (established under section 1395m(c)(3) of this title)'' after ''established by the Secretary''.

Pub. L. 100–360, §201(b), inserted at end ''A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1395*l*(c) of this title (relating to catastrophic benefits).''

Subsec. (a)(3)(C)(ii). Pub. L. 100–360, §411(j)(5), made technical correction to directory language of Pub. L. 100–203, §4097(b), see 1987 Amendment note below.

Subsec. (d). Pub. L. 100–360, §104(d)(5), as amended by Pub. L. 100–485, §608(d)(3)(F), struck out ''post-hospital'' before ''extended care services''.

Subsec. (f). Pub. L. 100–485, §608(f)(1), struck out subsec. (f) which provided for termination or decertification and alternatives thereto.

Subsec. (g). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(28), see 1987 Amendment note below.

1987—Subsec. (a)(1)(F)(i)(III). Pub. L. 100–203, §4097(a), substituted ''1988'' for ''1986'' and inserted ''and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year'' after ''inflation''.

Subsec. (a)(1)(O). Pub. L. 100–203, §4012(a), added subpar. (O).

Subsec. (a)(2)(A). Pub. L. 100–203, §4062(d)(4), inserted at end ''Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395*l*(b) of this title and 20 percent of the payment basis described in section 1395m(a)(2) of this title.''

Subsec. (a)(3). Pub. L. 100–93, §8(d)(1), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: ''The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or

managing employee (as defined in section 1320a–5(b) of this title) of such provider, is a person described in section 1320a–5(a) of this title.''

Subsec. (a)(3)(C)(ii). Pub. L. 100–203, § 4097(b), as amended by Pub. L. 100–360, § 411(j)(5), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of subchapter XI of this chapter.''

Subsec. (a)(4). Pub. L. 100–93, § 8(d)(1)(B), redesignated par. (4) as (3).

Subsec. (b). Pub. L. 100–93, § 8(d)(2), amended subsec. (b) generally, substituting pars. (1) to (3) for former pars. (1) to (5).

Subsec. (c)(1). Pub. L. 100–93, § 8(d)(3), (4), substituted ''the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services'' for ''an agreement filed under this subchapter by a provider of services has been terminated by the Secretary'' and inserted ''or nonrenewal'' after ''termination''.

Subsec. (c)(2). Pub. L. 100–203, § 4212(e)(4), redesignated par. (3) as (2) and struck out former par. (2) which read as follows: ''In the case of a skilled nursing facility participating in the programs established by this subchapter and subchapter XIX of this chapter, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1396i(a) of this title, and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.''

Subsec. (c)(3). Pub. L. 100–203, § 4212(e)(4), redesignated par. (3) as (2).

Pub. L. 100–93, § 8(d)(3), (4), substituted ''the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services'' for ''an agreement filed under this subchapter by a provider of services has been terminated by the Secretary'' and inserted ''or nonrenewal'' after ''termination''.

Subsec. (g). Pub. L. 100–203, § 4085(i)(28), as added by Pub. L. 100–360, § 411(i)(4)(C)(vi), substituted ''money penalty'' for ''monetary penalty'' in first sentence and amended second sentence generally. Prior to amendment, second sentence read as follows: ''Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section.''

Pub. L. 100–203, § 4085(i)(17), substituted ''inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement'' for ''for a hospital outpatient service for which payment may be made under part B of this subchapter and such bill or request violates an arrangement under subsection (a)(1)(H)''.

Subsec. (h). Pub. L. 100–93, § 8(d)(5), added subsec. (h).

1986—Subsec. (a)(1)(F). Pub. L. 99–509, § 9353(e)(1)(A), designated existing provisions as cl. (i) and in cl. (i), as so designated, redesignated former cls. (i) to (iii) as subcls. (I) to (III), and added cl. (ii).

Pub. L. 99–272, § 9402(a), redesignated cl. (iv) as (iii) and in cl. (iii), as so redesignated, substituted ''1986'' for ''1982'', and struck out former cl. (iii) which provided that the cost of such agreement to the hospital shall not be less than amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation).

Subsec. (a)(1)(H). Pub. L. 99–509, § 9343(c)(2), struck out ''inpatient hospital'' after ''hospitals which provide'' and substituted ''a patient'' for ''an inpatient''.

Pub. L. 99–509, § 9320(h)(2), inserted '', and other than services of a certified registered nurse anesthetist'' after ''section 1395y(a)(14) of this title''.

Subsec. (a)(1)(I). Pub. L. 99–514 redesignated subpar. (I) relating to agreement not to charge for certain items and services as subpar. (K).

Pub. L. 99–272, § 9403(b), added subpar. (I) relating to agreement not to charge for certain items or services.

Pub. L. 99–272, § 9121(a), added subpar. (I) relating to compliance with the requirements of section 1395dd of this title.

Subsec. (a)(1)(J). Pub. L. 99–272, § 9122(a), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 99–514 redesignated subpar. (I) relating to agreement not to charge for certain items and services as subpar. (K).

Subsec. (a)(1)(L). Pub. L. 99–576 added subpar. (L).

Subsec. (a)(1)(M). Pub. L. 99–509, § 9305(b)(1), added subpar. (M).

Subsec. (a)(1)(N). Pub. L. 99–509, § 9332(e)(1), added subpar. (N).

Subsec. (a)(2)(A). Pub. L. 99–272, § 9401(b)(2)(F), inserted '', with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),'' after ''1395x(s)(10)(A) of this title'' in last sentence.

Subsec. (a)(4). Pub. L. 99–509, § 9353(e)(1)(B), added par. (4).

Subsec. (e). Pub. L. 99–509, § 9337(c)(2), inserted ''(or meets the requirements of such section through the operation of section 1395x(g) of this title)'' in two places, and inserted ''or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services'' after ''(as therein defined)''.

Subsec. (g). Pub. L. 99–509, § 9343(c)(3), added subsec. (g).

1984—Subsec. (a)(1)(E). Pub. L. 98–369, § 2354(b)(33), inserted a comma at end.

Subsec. (a)(1)(F). Pub. L. 98–369, § 2347(a)(2), repealed amendment made by Pub. L. 98–21, § 602(*l*)(1). See 1983 Amendment note below.

Pub. L. 98–369, § 2347(a)(1), substituted ''maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located, under which the organization'' for ''maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located) under which the organization''.

Pub. L. 98–369, § 2315(d), substituted ''(b), (c), or (d)'' for ''(c) or (d)''.

Subsec. (a)(2)(A). Pub. L. 98–369, § 2323(b)(3), substituted ''section 1395x(s)(10)(A) of this title'' for ''section 1395x(s)(10) of this title''.

Pub. L. 98–369, § 2321(c), inserted ''or which are durable medical equipment furnished as home health services'' after ''part B''.

Pub. L. 98–369, § 2303(f), inserted ''and with respect to clinical diagnostic laboratory tests'' after ''section 1395x(s)(10) of this title''.

Subsec. (b)(3). Pub. L. 98–369, § 2354(b)(34), realigned margin.

Pub. L. 98–369, § 2335(d)(1), substituted ''(including inpatient psychiatric hospital services)'' for ''(including tuberculosis hospital services and inpatient psychiatric hospital services)''.

Subsec. (b)(4). Pub. L. 98–369, § 2348(a), substituted ''more than 30 days after such effective date'' for ''after the calendar year in which such termination is effective''.

Subsec. (d). Pub. L. 98–369, § 2335(d)(2), substituted ''(including inpatient psychiatric hospital services)'' for ''(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services)''.

1983—Subsec. (a)(1). Pub. L. 98–21, § 602(*l*)(2), inserted provision at end of par. (1) that in the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's

contract with the Secretary under part B of subchapter XI terminates on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

Subsec. (a)(1)(F). Pub. L. 98–21, §602(*l*)(1), which provided that, effective Oct. 1, 1984, subpar. (F) is amended by substituting ''(with an organization'' for ''(if there is such an organization'', was repealed by Pub. L. 98–369, §2347(a)(2), effective July 18, 1984.

Subsec. (a)(1)(F) to (H). Pub. L. 98–21, §602(f)(1), added subpars. (F) to (H).

Subsec. (a)(2)(A). Pub. L. 97–448, §309(b)(11), inserted a comma after ''1395e(a)(1)''.

Pub. L. 97–448, §309(a)(5), amended directory language of Pub. L. 97–248, §122(g)(5), to correct an error, and did not involve any change in text. See 1982 Amendment note below.

Subsec. (a)(2)(B)(ii). Pub. L. 98–21, §602(f)(2), inserted ''and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1395ww(d) of this title'' after ''(except with respect to emergency services)'' in provision preceding subcl. (I).

1982—Subsec. (a)(1)(B). Pub. L. 97–248, §128(d)(4), inserted ''of section 1395y(a) of this title''.

Subsec. (a)(1)(E). Pub. L. 97–248, §144, added subpar. (E).

Subsec. (a)(2)(A). Pub. L. 97–248, §122(g)(5), as amended by Pub. L. 97–448, §309(a)(5), substituted ''(a)(3), or (a)(4)'' for ''or (a)(3)''.

Subsec. (b). Pub. L. 97–248, §128(a)(5), in provisions preceding par. (1), struck out ''(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)'' after ''may be terminated''.

Subsec. (b)(4)(A). Pub. L. 97–248, §122(g)(6), inserted ''or hospice care'' after ''home health services''.

1981—Subsec. (a)(1). Pub. L. 97–35 struck out provision following subpar. (D) which provided that an agreement with a skilled nursing facility be for a term not exceeding 12 months with the exception that the Secretary could extend the time in specified situations.

1980—Subsec. (a)(2)(A). Pub. L. 96–611 inserted provision that a provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10) of this title for which payment is made under part B of this subchapter.

Subsec. (c)(3). Pub. L. 96–272 added par. (3).

Subsec. (f). Pub. L. 96–499 added subsec. (f).

1978—Subsec. (a)(2)(A). Pub. L. 95–292 provided for computation of and charging of coinsurance amounts for items and services furnished individuals with end stage renal disease on the basis established by the Secretary.

1977—Subsec. (a)(1)(D). Pub. L. 95–142, §15(a), added subpar. (D).

Subsec. (a)(3). Pub. L. 95–142, §8(b)(1), added par. (3).

Subsec. (b)(2)(C). Pub. L. 95–142, §3(b), designated existing provisions as subcl. (i) and added subcl. (ii).

Subsec. (b)(2)(F). Pub. L. 95–142, §13(b)(3), substituted ''of a quality which fails to meet professionally recognized standards of health care'' for ''harmful to individuals or to be of a grossly inferior quality'', and struck out provisions relating to approval by an appropriate program review team.

Subsec. (b)(2)(G). Pub. L. 95–142, §8(b)(2), added cl. (G).

Subsec. (c)(2). Pub. L. 95–210 substituted ''section 1396i(a) of this title'' for ''section 1396i of this title''.

1972—Subsec. (a)(1). Pub. L. 92–603, §§227(d)(2), 249A(b), 278(a)(17), (b)(18), 281(c), substituted ''Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title)'' for ''Any provider of services'', ''skilled nursing facility'' for ''extended care facility'', inserted provision that the agreement be for a term of not to exceed 12 months with an allowable extension of 2 months under specified circumstances, redesignated subpar. (B) as (C) and added subpar. (B).

Subsec. (a)(2)(B). Pub. L. 92–603, §223(e), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(C). Pub. L. 92–603, §223(g)(2), substituted ''this subparagraph'' for ''clause (iii) of the preceding sentence''.

Subsec. (a)(2)(D). Pub. L. 92–603, §223(g)(1), added subpar. (D).

Subsec. (b). Pub. L. 92–603, §§229(b), 249A(c), 278(a)(17), inserted ''(and in the case of an extended care facility, prior to the end of the term specified in subsection (a)(1) of this section)'' in provision preceding par. (1), in par. (2), added cls. (D) to (F), and in par. (3), substituted ''(including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to'' for ''(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after'' and substituted ''skilled nursing facility'' for ''extended care facility''.

Subsec. (c). Pub. L. 92–603, §249A(d), designated existing provisions as par. (1) and added par. (2).

Subsec. (d). Pub. L. 92–603, §278(a)(17), substituted ''skilled nursing facility'' for ''extended care facility'' and ''a'' for ''an''.

1968—Subsec. (a)(2)(A). Pub. L. 90–248, §129(c)(12)(A)(i), (ii), substituted ''or (a)(3)'' for '', (a)(2), or (a)(4)'' in cl. (i), and deleted ''or, in the case of outpatient hospital diagnostic services, for which payment is made under part A'' in cl. (ii).

Subsec. (a)(2)(C). Pub. L. 90–248, §129(c)(12)(B), substituted ''1395e(a)(2)'' for ''1395e(a)(3)''.

Pub. L. 90–248, §135(b), authorized a provider of services to charge for blood in accordance with its customary practices, included, in addition to whole blood for which a provider of services may charge, equivalent quantities of packed red blood cells, and provided that blood furnished an individual will be deemed replaced when the provider is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the three pint deductible applies.

Subsec. (e). Pub. L. 90–248, §133(c), added subsec. (e).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 125(b)(1), (2)(A) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–182 effective on the date described in section 101(b) of Pub. L. 115–182, see section 144(b) of Pub. L. 115–182, set out as a note under section 1712 of Title 38, Veterans' Benefits.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6406(b) of Pub. L. 111–148 applicable to orders, certifications, and referrals made on

or after Jan. 1, 2010, see section 6406(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, § 236(c), Dec. 8, 2003, 117 Stat. 2212, provided that: ''The amendments made by this section [amending this section and sections 1395eee, 1396a, and 1396u–4 of this title] shall apply to services furnished on or after January 1, 2004.''

Amendment by section 505(b) of Pub. L. 108–173 first applicable to the wage index for discharges occurring on or after Oct. 1, 2004, see section 505(c) of Pub. L. 108–173, set out as a note under section 1395ww of this title.

Pub. L. 108–173, title V, § 506(b), Dec. 8, 2003, 117 Stat. 2295, provided that: ''The amendments made by this section [amending this section] shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act [Dec. 8, 2003]) to medicare participation agreements in effect (or entered into) on or after such date.''

Amendment by section 932(b), (c)(1) of Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section 932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

Pub. L. 108–173, title IX, § 936(b), Dec. 8, 2003, 117 Stat. 2412, provided that:

''(1) ENROLLMENT PROCESS.—The Secretary [of Health and Human Services] shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act [42 U.S.C. 1395cc(j)(1)], as added by subsection (a)(2), within 6 months after the date of the enactment of this Act [Dec. 8, 2003].

''(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act [42 U.S.C. 1395cc(j)(1)(C)], as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

''(3) HEARING RIGHTS.—Section 1866(j)(2) [now 1866(j)(8)] of the Social Security Act [42 U.S.C. 1395cc(j)(8)], as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]) as the Secretary specifies.''

Pub. L. 108–173, title IX, § 947(b), Dec. 8, 2003, 117 Stat. 2425, provided that: ''The amendments made by this [sic] subsection (a) [amending this section] shall apply to hospitals as of July 1, 2004.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2001, see section 1(a)(6) [title III, § 313(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4302(a) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to the entry and renewal of contracts on or after such date, see section 4302(c) of Pub. L. 105–33, set out as a note under section 1395u of this title.

Amendment by section 4321(b) of Pub. L. 105–33 effective as of date specified by Secretary of Health and Human Services in regulations to be issued by Secretary not later than date which is one year after Aug. 5, 1997, see section 4321(d)(2) of Pub. L. 105–33, set out as an Effective Date note under section 1320b–16 of this title.

Amendment by section 4432(b)(5)(F) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(a)(2)(D) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4541(a)(3) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1999, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Pub. L. 105–33, title IV, § 4641(b), Aug. 5, 1997, 111 Stat. 487, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997]) as the Secretary of Health and Human Services specifies.''

Amendments by section 4714(b)(1) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 106(b)(2), Oct. 31, 1994, 108 Stat. 4406, provided that: ''The amendments made by paragraph (1) [amending this section and section 1395f of this title] shall take effect as if included in the enactment of OBRA–1987 [Pub. L. 100–203].''

Amendment by section 147(e)(7) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Amendment by section 156(a)(2)(E) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4008(b)(4), Nov. 5, 1990, 104 Stat. 1388–44, provided that: ''The amendments made by this subsection [amending this section and section 1395dd of this title] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, § 4153(d)(2), Nov. 5, 1990, 104 Stat. 1388–84, as amended by Pub. L. 103–432, title I, § 135(e)(7), Oct. 31, 1994, 108 Stat. 4424, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

Amendment by section 4157(c)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991,

see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4162(b)(2) of Pub. L. 101–508 applicable with respect to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4206(a) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(1) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6018(b), Dec. 19, 1989, 103 Stat. 2165, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date.''

Amendment by section 6112(e)(3) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6112(e)(4) of Pub. L. 101–239, set out as a note under section 1395m of this title.

Amendment by section 101(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 608(d)(3)(F), (19)(A) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, and amendment by section 608(f)(1) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(1), (2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(5) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 202(h)(1) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(2)(C), (g)(1)(D), (i)(4)(C)(vi), (j)(5) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(c)(2)(A)(ii), July 1, 1988, 102 Stat. 773, provided that: ''The amendment made by clause (i) [amending this section] shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act [July 1, 1988].''

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4012(a) of Pub. L. 100–203 applicable to admissions occurring on or after Apr. 1, 1988, or, if later, the earliest date the Secretary can provide the information required under section 4012(c) of Pub. L. 100–203 [42 U.S.C. 1395mm note] in machine readable form, see section 4012(d) of Pub. L. 100–203, set out as a note under section 1395mm of this title.

Amendment by section 4062(d)(4) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4085(i)(17), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment made by such section 4085(i)(17) is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, §4097(c), Dec. 22, 1987, 101 Stat. 1330–140, provided that: ''The amendments made by this section [amending this section] shall apply with respect to fiscal years beginning on or after October 1, 1988.''

Amendment by section 4212(e)(4) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–576, title II, §233(b), Oct. 28, 1986, 100 Stat. 3265, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring after June 30, 1987.''

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9305(b)(2), Oct. 21, 1986, 100 Stat. 1989, provided that: ''The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(M)] not later than six months after the date of the enactment of this Act [Oct. 21, 1986]. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.''

Amendment by section 9320(h)(2) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9332(e)(2), Oct. 21, 1986, 100 Stat. 2025, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to agreements under section 1866(a) of the Social Security Act [42 U.S.C. 1395cc(a)] as of October 1, 1987.''

Amendment by section 9337(c)(2) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Amendment by section 9343(c)(2), (3) of Pub. L. 99–509 applicable to services furnished after June 30, 1987, see section 9343(h)(4) of Pub. L. 99–509, as amended, set out as a note under section 1395*l* of this title.

Pub. L. 99–509, title IX, §9353(e)(3)(A), Oct. 21, 1986, 100 Stat. 2049, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to provider agreements as of October 1, 1987.''

Amendment by section 9121(a) of Pub. L. 99–272 effective on first day of first month that begins at least 90

days after Apr. 7, 1986, see section 9121(c) of Pub. L. 99–272, set out as a note under section 1395dd of this title.

Pub. L. 99–272, title IX, § 9122(b), Apr. 7, 1986, 100 Stat. 167, as amended by Pub. L. 99–514, title XVIII, § 1895(b)(6), Oct. 22, 1986, 100 Stat. 2933, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.''

Pub. L. 99–272, title IX, § 9402(c)(1), Apr. 7, 1986, 100 Stat. 200, provided that: ''The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

Amendment by section 9403(b) of Pub. L. 99–272 effective Apr. 7, 1986, see section 9403(c) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2303(f) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1), (3) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Amendment by section 2315(d) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendment note under section 1395ww of this title.

Amendment by section 2321(c) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2323(b)(3) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Amendment by section 2335(d) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2347(a) of Pub. L. 98–369 effective July 18, 1984, see section 2347(d) of Pub. L. 98–369, set out as a note under section 1320c–2 of this title.

Pub. L. 98–369, div. B, title III, § 2348(b), July 18, 1984, 98 Stat. 1097, provided that: ''The amendment made by this section [amending this section] shall apply to terminations issued on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(33), (34) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title VI, § 602(*l*), Apr. 20, 1983, 97 Stat. 166, as amended by Pub. L. 98–369, div. B, title III, § 2347(a)(2), July 18, 1984, 98 Stat. 1096, provided that the amendment made by that section is effective Oct. 1, 1984.

Amendment by section 602(f)(2) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Subsec. (a)(1)(F) to (H) of this section, as added by section 602(f)(1)(C) of Pub. L. 98–21, effective Oct. 1, 1983, see section 604(a)(2) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by section 309(a)(5) of Pub. L. 97–448 effective as if originally included in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, to which such amendment relates, see section 309(c)(1) of Pub. L. 97–448, set out as a note under section 426 of this title.

Amendment by section 309(b)(11) of Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(g)(5), (6) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(a)(5) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by section 128(d)(4) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by section 144 of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–210, § 2(f), Dec. 13, 1977, 91 Stat. 1489, provided that:

''(1) The amendments made by this section [amending this section and sections 1396a, 1396d, and 1396i of this title] shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act [Dec. 13, 1977].

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title [42 U.S.C. 1396 et seq.] solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature

that begins after the date of enactment of this Act [Dec. 13, 1977].''

Amendment by section 3(b) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 8(b) of Pub. L. 95–142 [amending this section] applicable with respect to contracts, agreements, etc., made on and after first day of fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–5 of this title.

Amendment by section 13(b)(3) of Pub. L. 95–142 effective Oct. 25, 1977, see section 13(c) of Pub. L. 95–142, set out as a note under section 1395y of this title.

Pub. L. 95–142, §15(b), Oct. 25, 1977, 91 Stat. 1200, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act [Oct. 25, 1977].''

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 223(e), (g) of Pub. L. 92–603 effective with respect to accounting periods beginning after Dec. 31, 1972, see section 223(h) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 227(d)(2) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §249A(e), Oct. 30, 1972, 86 Stat. 1427, provided that: ''The provisions of this section [enacting section 1396 of this title and amending this section] shall be effective with respect to agreements filed with the Secretary under section 1866 of the Social Security Act [42 U.S.C. 1395cc] by skilled nursing facilities (as defined in section 1861(j) of such Act [42 U.S.C. 1395x(j)]) before, on, or after the date of enactment of this Act [Oct. 30, 1972], but accepted by him on or after such date.''

Amendment by section 281(c) of Pub. L. 92–603 applicable in the case of notices sent to individuals after 1968, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(12) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 133(c) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Amendment by section 135(b) of Pub. L. 90–248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub. L. 90–248, set out as a note under section 1395e of this title.

REGULATIONS

Pub. L. 108–173, title V, §506(c), Dec. 8, 2003, 117 Stat. 2295, provided that: ''The Secretary [of Health and Human Services] shall promulgate regulations to carry out the amendments made by subsection (a) [amending this section].''

RULE OF CONSTRUCTION

Nothing in section 102 of div. BB of Pub. L. 116–260 to be construed as modifying, reducing, or eliminating the requirements under 42 U.S.C. 1395cc(a)(1)(U), see section 102(d)(3) of div. BB of Pub. L. 116–260, set out as a note under section 1621u of Title 25, Indians.

DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES

Pub. L. 111–148, title VI, §6401(b)(2), Mar. 23, 2010, 124 Stat. 752, provided that: ''The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each [sic] State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or a child health plan under title XXI [42 U.S.C. 1397aa et seq.] the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII [42 U.S.C. 1395 et seq.] or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act [Mar. 23, 2010], within 90 days of such date).''

OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE

Pub. L. 110–275, title I, §187, July 15, 2008, 122 Stat. 2588, provided that:

''(a) REPORT.—Not later than two years after the date of the enactment of this Act [July 15, 2008], the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

''(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

''(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

''(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.''

GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE

Pub. L. 108–173, title VI, §650, Dec. 8, 2003, 117 Stat. 2331, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

''(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

''(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(2) CONCIERGE CARE.—In this section, the term 'concierge care' means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

''(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

''(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

''(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act [Dec. 8,

2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.''

EFFECT ON STATE LAW

Pub. L. 101–508, title IV, § 4206(c), Nov. 5, 1990, 104 Stat. 1388–116, provided that: ''Nothing in subsections (a) and (b) [amending this section and sections 1395*l* and 1395mm of this title] shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.''

REPORTS TO CONGRESS ON NUMBER OF HOSPITALS TERMINATING OR NOT RENEWING PROVIDER AGREEMENTS

Pub. L. 99–576, title II, § 233(c), Oct. 28, 1986, 100 Stat. 3265, provided that:

''(1) The Secretary of Health and Human Services shall periodically submit to the Congress a report on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].

''(2) Not later than October 1, 1987, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding implementation of this section [amending this section]. Thereafter, the Administrator shall notify such committees if any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons described in that paragraph.''

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 7 on page 96 identifies a report on ''Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed'' authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

Pub. L. 99–272, title IX, § 9122(d), Apr. 7, 1986, 100 Stat. 167, provided that: ''The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].''

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 7 on page 96 identifies a report on ''Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed'' authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

DELAY IN IMPLEMENTATION OF REQUIREMENT THAT HOSPITALS MAINTAIN AGREEMENTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

Pub. L. 98–369, div. B, title III, § 2347(b), July 18, 1984, 98 Stat. 1096, provided that: ''Notwithstanding section 604(a)(2) of the Social Security Amendments of 1983 [section 604(a)(2) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 1395ww of this title], the requirement that a hospital maintain an agreement with a utilization and quality control peer review [now ''quality improvement''] organization, as contained in section 1866(a)(1)(F) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(F)], shall become effective on November 15, 1984.''

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS' SERVICES

For authority to waive the requirements of subsec. (a)(1)(H) of this section for any cost period prior to Oct. 1, 1986, where immediate compliance would threaten the stability of patient care, see section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title.

PRIVATE SECTOR REVIEW INITIATIVE

Pub. L. 97–248, title I, § 119, Sept. 3, 1982, 96 Stat. 355, provided that:

''(a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

''(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title [42 U.S.C. 1395cc, 1395pp], from collecting any payments from beneficiaries unless otherwise provided under such title.''

AGREEMENTS FILED AND ACCEPTED PRIOR TO OCT. 30, 1972, DEEMED TO BE FOR SPECIFIED TERM ENDING DEC. 31, 1973

Pub. L. 92–603, title II, § 249A(f), Oct. 30, 1972, 86 Stat. 1427, provided that: ''Notwithstanding any other provision of law, any agreement, filed by a skilled nursing facility (as defined in section 1861(j) of the Social Security Act [42 U.S.C. 1395x(j)]) with the Secretary under section 1866 of such Act [42 U.S.C. 1395cc] and accepted by him prior to the date of enactment of this Act [Oct. 30, 1972], which was in effect on such date shall be deemed to be for a specified term ending on December 31, 1973.''

§ 1395cc–1. Demonstration of application of physician volume increases to group practices

(a) Demonstration program authorized

(1) In general

The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this subchapter that—

(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

(C) reward physicians for improving health outcomes.

Such projects shall focus on the efficiencies of furnishing health care in a group-practice setting as compared to the efficiencies of furnishing health care in other health care delivery systems.

(2) Administration by contract

Except as otherwise specifically provided, the Secretary may administer the program

under this section in accordance with section 1395cc–2 of this title.

(3) Definitions

For purposes of this section, terms have the following meanings:

(A) Physician

Except as the Secretary may otherwise provide, the term ''physician'' means any individual who furnishes services which may be paid for as physicians' services under this subchapter.

(B) Health care group

The term ''health care group'' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this subchapter. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

(b) Eligibility criteria

(1) In general

The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

(2) Payment method

A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

(A) to be paid on a fee-for-service basis; and

(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

(3) Data reporting

A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary requires, for purposes of monitoring and evaluation of the demonstration under this section.

(c) Patients within scope of demonstration

(1) In general

The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

(2) Other criteria

The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

(3) Notice requirements

In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

(d) Incentives

(1) Performance target

The Secretary shall establish for each health care group participating in a demonstration under this section—

(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

(2) Incentive bonus

The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the medicare savings realized for such year relative to the performance target.

(3) Additional bonus for process and outcome improvements

At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this subchapter resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

(4) Limitation

The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this subchapter (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

(Aug. 14, 1935, ch. 531, title XVIII, §1866A, as added Pub. L. 106–554, §1(a)(6) [title IV, §412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–509.)

Statutory Notes and Related Subsidiaries

GAO REPORT

Pub. L. 106–554, §1(a)(6) [title IV, §412(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–515, provided that: ''Not later than 2 years after the date on which the demonstration project under section 1866A of the Social Security Act [42 U.S.C. 1395cc–1], as added by subsection (a), is implemented, the Comptroller General of the United States shall submit to Congress a report on such demonstration project. The report shall include such recommendations with respect to changes to the demonstration project that the Comptroller General determines appropriate.''

§ 1395cc–2. Provisions for administration of demonstration program

(a) General administrative authority

(1) Beneficiary eligibility

Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1395cc–1 of this title (in this section referred to as the ''demonstration program'') if such individual—

(A) is enrolled under the program under part B and entitled to benefits under part A; and

(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1395mm of this title (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1395*l*(a)(1)(A) of this title, or a PACE program under section 1395eee of this title.

(2) Secretary's discretion as to scope of program

The Secretary may limit the implementation of the demonstration program to—

(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

(D) any combination of any of the limits described in subparagraphs (A) through (C).

(3) Voluntary receipt of items and services

Items and services shall be furnished to an individual under the demonstration program only at the individual's election.

(4) Agreements

The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

(5) Program standards and criteria

The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(6) Administrative review of decisions affecting individuals and entities furnishing services

An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

(7) Secretary's review of marketing materials

An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials that market items or services under the program without the Secretary's prior review and approval.

(8) Payment in full

(A) In general

Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this subchapter.

(B) Collection of deductibles and coinsurance

Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

(b) Contracts for program administration

(1) In general

The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

(2) Scope of program administrator contracts

The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

(3) Eligible contractors

The Secretary may contract for the administration of the program with—

(A) an entity that, under a contract under section 1395h or 1395u of this title, determines the amount of and makes payments for health care items and services furnished under this subchapter; or

(B) any other entity with substantial experience in managing the type of program concerned.

(4) Contract award, duration, and renewal

(A) In general

A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

(B) Noncompetitive award and renewal for entities administering part A or part B payments

The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 6101 of title 41.

(5) Applicability of Federal Acquisition Regulation

The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

(6) Performance standards

The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(7) Functions of program administrator

A program administrator shall perform any or all of the following functions, as specified by the Secretary:

(A) Agreements with entities furnishing health care items and services

Determine the qualifications of entities seeking to enter or renew agreements to provide services under the demonstration program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

(B) Establishment of payment rates

Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

(C) Payment of claims or fees

Administer payments for health care items or services furnished under the program.

(D) Payment of bonuses

Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (c)(2)(B) to entities furnishing items or services for which payment may be made under the program.

(E) Oversight

Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

(F) Administrative review

Conduct reviews of adverse determinations specified in subsection (a)(6).

(G) Review of marketing materials

Conduct a review of marketing materials proposed by an entity furnishing services under the program.

(H) Additional functions

Perform such other functions as the Secretary may specify.

(8) Limitation of liability

The provisions of section 1320c–6(b) of this title shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

(9) Information sharing

Notwithstanding section 1306 of this title and section 552a of title 5, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

(c) Rules applicable to both program agreements and program administration contracts

(1) Records, reports, and audits

The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

(2) Bonuses

Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the demonstration program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

(A) Payments to program administrators

The Secretary may make bonus payments under the program to program administrators.

(B) Payments to entities furnishing services

(i) In general

Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the demonstration program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

(ii) Limitations

The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

(3) Antidiscrimination limitation

The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1)[1] of the Public Health Service Act.

(d) Limitations on judicial review

The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

(1) Limiting the implementation of the program under subsection (a)(2).

(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

(4) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

(5) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

(A) as to whether cost savings have been achieved, and the amount of savings; or

(B) as to whether, to whom, and in what amounts bonuses will be paid.

(e) Application limited to parts A and B

None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

(f) Reports to Congress

Not later than two years after December 21, 2000, and biennially thereafter for six years, the Secretary shall report to Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866B, as added Pub. L. 106–554, § 1(a)(6) [title IV, § 412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–511; amended Pub. L. 108–173, title VII, § 736(c)(5), Dec. 8, 2003, 117 Stat. 2356.)

[1] See References in Text note below.

Editorial Notes

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (c)(3), is section 2702 of act July 1, 1944, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, § 1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (d) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

CODIFICATION

In subsec. (b)(4)(B), ''section 6101 of title 41'' substituted for ''section 5 of title 41, United States Code'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2003—Subsec. (b)(7)(D). Pub. L. 108–173 substituted ''(c)(2)(B)'' for ''(c)(2)(A)(ii)''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

§ 1395cc–3. Health care quality demonstration program

(a) Definitions

In this section:

(1) Beneficiary

The term ''beneficiary'' means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

(2) Health care group

(A) In general

The term ''health care group'' means—

(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this subchapter;

(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

(B) Inclusion

As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrange-

ment structured so that such hospital, individual, or entity participates in a demonstration project under this section.

(3) Physician

Except as otherwise provided for by the Secretary, the term ''physician'' means any individual who furnishes services that may be paid for as physicians' services under this subchapter.

(b) Demonstration projects

The Secretary shall establish a demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

(1) the provision of incentives to improve the safety of care provided to beneficiaries;

(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

(4) encourage shared decision making between providers and patients;

(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

(c) Administration by contract

(1) In general

Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1395cc–1 of this title is administered in accordance with section 1395cc–2 of this title.

(2) Alternative payment systems

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

(B) streamline documentation and reporting requirements otherwise required under this subchapter.

(3) Benefits

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

(d) Eligibility criteria

To be eligible to receive assistance under this section, an entity shall—

(1) be a health care group;

(2) meet quality standards established by the Secretary, including—

(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

(C) encouraging patient participation in preference-based decisions;

(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

(3) meet such other requirements as the Secretary may establish.

(e) Waiver authority

The Secretary may waive such requirements of this subchapter and subchapter XI as may be necessary to carry out the purposes of the demonstration program established under this section.

(f) Budget neutrality

With respect to the period of the demonstration program under subsection (b), the aggregate expenditures under this subchapter for such period shall not exceed the aggregate expenditures that would have been expended under this subchapter if the program established under this section had not been implemented.

(g) Notice requirements

In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this subchapter as a result of the participation of the individual in such program.

(h) Participation and support by Federal agencies

In carrying out the demonstration program under this section, the Secretary may direct—

(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866C, as added Pub. L. 108–173, title VI, § 646, Dec. 8, 2003, 117 Stat. 2324; amended Pub. L. 111–148, title III, § 3021(c), Mar. 23, 2010, 124 Stat. 395.)

Editorial Notes

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see section 1(a) of Pub. L. 104–191, set out as a Short Title of 1996 Amendments note under section 201 of this title and Tables.

AMENDMENTS

2010—Subsec. (b). Pub. L. 111–148 struck out ''5-year'' before ''demonstration program'' in introductory provisions.

Subsec. (f). Pub. L. 111–148 struck out ''5-year'' before ''period of the demonstration program''.

§ 1395cc–4. National pilot program on payment bundling

(a) Implementation

(1) In general

The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this subchapter.

(2) Definitions

In this section:

(A) Applicable beneficiary

The term ''applicable beneficiary'' means an individual who—

(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such subchapter, but not enrolled under part C or a PACE program under section 1395eee of this title; and

(ii) is admitted to a hospital for an applicable condition.

(B) Applicable condition

The term ''applicable condition'' means 1 or more of 10 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

(i) Whether the conditions selected include a mix of chronic and acute conditions.

(ii) Whether the conditions selected include a mix of surgical and medical conditions.

(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this subchapter.

(iv) Whether a condition has significant variation in—

(I) the number of readmissions; and

(II) the amount of expenditures for post-acute care spending under this subchapter.

(v) Whether a condition is high-volume and has high post-acute care expenditures under this subchapter.

(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this subchapter.

(C) Applicable services

The term ''applicable services'' means the following:

(i) Acute care inpatient services.

(ii) Physicians' services delivered in and outside of an acute care hospital setting.

(iii) Outpatient hospital services, including emergency department services.

(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

(v) Other services the Secretary determines appropriate.

(D) Episode of care

(i) In general

Subject to clause (ii), the term ''episode of care'' means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

(II) the length of stay of the applicable beneficiary in such hospital; and

(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

(ii) Establishment of period by the Secretary

The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

(E) Physicians' services

The term ''physicians' services'' has the meaning given such term in section 1395x(q) of this title.

(F) Pilot program

The term ''pilot program'' means the pilot program under this section.

(G) Provider of services

The term ''provider of services'' has the meaning given such term in section 1395x(u) of this title.

(H) Readmission

The term ''readmission'' has the meaning given such term in section 1395ww(q)(5)(E) of this title.

(I) Supplier

The term ''supplier'' has the meaning given such term in section 1395x(d) of this title.

(3) Deadline for implementation

The Secretary shall establish the pilot program not later than January 1, 2013.

(b) Developmental phase

(1) Determination of patient assessment instrument

The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

(2) Development of quality measures for an episode of care and for post-acute care

(A) In general

The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1395aaa(a) of this title, shall develop quality measures for use in the pilot program—

(i) for episodes of care; and

(ii) for post-acute care.

(B) Site-neutral post-acute care quality measures

Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

(C) Coordination with quality measure development and endorsement procedures

The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section[1] 1395aaa and 1395aaa–1 of this title that are applicable to all post-acute care settings.

(c) Details

(1) Duration

(A) In general

Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

(B) Expansion

The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

(i) the Secretary determines that such expansion is expected to—

(I) reduce spending under this subchapter without reducing the quality of care; or

(II) improve the quality of care and reduce spending;

(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this subchapter; and

(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this subchapter for individuals.

(2) Participating providers of services and suppliers

(A) In general

An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this subchapter, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

(B) Requirements

The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

(3) Payment methodology

(A) In general

(i) Establishment of payment methods

The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

(ii) No additional program expenditures

Payments under this section for applicable items and services under this subchapter (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(B) Inclusion of certain services

A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

[1] So in original. Probably should be ''sections''.

(C) Bundled payments

(i) In general

A bundled payment under the pilot program shall—

(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

(II) be made to the entity which is participating in the pilot program.

(ii) Requirement for provision of applicable services and other appropriate services

Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

(D) Payment for post-acute care services after the episode of care

The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

(4) Quality measures

(A) In general

The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

(i) Functional status improvement.

(ii) Reducing rates of avoidable hospital readmissions.

(iii) Rates of discharge to the community.

(iv) Rates of admission to an emergency room after a hospitalization.

(v) Incidence of health care acquired infections.

(vi) Efficiency measures.

(vii) Measures of patient-centeredness of care.

(viii) Measures of patient perception of care.

(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

(B) Reporting on quality measures

(i) In general

A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

(ii) Submission of data through electronic health record

To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 300jj(13) of this title) in a manner specified by the Secretary.

(d) Waiver

The Secretary may waive such provisions of this subchapter and subchapter XI as may be necessary to carry out the pilot program.

(e) Independent evaluation and reports on pilot program

(1) Independent evaluation

The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

(A) improved quality measures established under subsection (c)(4)(A);

(B) improved health outcomes;

(C) improved applicable beneficiary access to care; and

(D) reduced spending under this subchapter.

(2) Reports

(A) Interim report

Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

(B) Final report

Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

(f) Consultation

The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1395x(mm)(1) of this title), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

(g) Application of pilot program to continuing care hospitals

(1) In general

In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

(2) Special rules

In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

(3) Continuing care hospital defined

In this subsection, the term ''continuing care hospital'' means an entity that has dem-

onstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1395ww(d)(1)(B)(ii) of this title), long term care hospitals (as defined in section 1395ww(d)(1)(B)(iv)(I)[2] of this title), and skilled nursing facilities (as defined in section 1395i–3(a) of this title) that are located in a hospital described in section 1395ww(d) of this title.

(h) Administration

Chapter 35 of title 44 shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866D, as added and amended Pub. L. 111–148, title III, § 3023, title X, § 10308(a), (b)(1), Mar. 23, 2010, 124 Stat. 399, 941, 942.)

Editorial Notes

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsec. (a)(2)(A)(i), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

Section 1395ww(d)(1)(B)(iv)(I) of this title, referred to in subsec. (g)(3), was redesignated section 1395ww(d)(1)(B)(iv) of this title by Pub. L. 114–255, div. C, title XV, § 15008(a)(3), Dec. 13, 2016, 130 Stat. 1321.

CODIFICATION

Another section 1866D of act Aug. 14, 1935, was renumbered section 1866E and is classified to section 1395cc–5 of this title.

AMENDMENTS

2010—Pub. L. 111–148, § 10308(b)(1), made technical correction to directory language of Pub. L. 111–148, § 3023, which enacted this section.

Subsec. (a)(2)(B). Pub. L. 111–148, § 10308(a)(1), substituted ''10 conditions'' for ''8 conditions''.

Subsec. (c)(1)(B). Pub. L. 111–148, § 10308(a)(2), added subpar. (B) and struck out former subpar. (B). Prior to amendment, text read as follows: ''The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this subchapter.''

Subsec. (g). Pub. L. 111–148, § 10308(a)(3), added subsec. (g) and struck out former subsec. (g). Prior to amendment, text read as follows: ''Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this subchapter.''

§ 1395cc–5. Independence at home medical practice demonstration program

(a) Establishment

(1) In general

The Secretary shall conduct a demonstration program (in this section referred to as the ''demonstration program'') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this subchapter to applicable beneficiaries (as defined in subsection (d)).

(2) Requirement

The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

(A) reducing preventable hospitalizations;

(B) preventing hospital readmissions;

(C) reducing emergency room visits;

(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

(F) reducing the cost of health care services covered under this subchapter; and

(G) achieving beneficiary and family caregiver satisfaction.

(b) Independence at home medical practice

(1) Independence at home medical practice defined

In this section:

(A) In general

The term ''independence at home medical practice'' means a legal entity that—

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

(ii) is organized at least in part for the purpose of providing physicians' services;

(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as

[2] See References in Text note below.

specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) Physician

The term ''physician'' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

(2) Participation of nurse practitioners and physician assistants

Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

(3) Inclusion of providers and practitioners

Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1395u(b)(18)(C) of this title that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

(4) Quality and performance standards

The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) Payment methodology

(1) Establishment of target spending level

The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

(2) Incentive payments

Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

(d) Applicable beneficiaries

(1) Definition

In this section, the term ''applicable beneficiary'' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

(A) is entitled to benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1395eee of this title;

(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this subchapter;

(D) within the past 12 months has had a nonelective hospital admission;

(E) within the past 12 months has received acute or subacute rehabilitation services;

(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

(G) meets such other criteria as the Secretary determines appropriate.

(2) Patient election to participate

The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

(3) Beneficiary access to services

Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this subchapter and applicable beneficiaries shall not be required to relinquish access to any benefit under this subchapter as a condition of receiving services from an independence at home medical practice.

(e) Implementation

(1) Starting date

The demonstration program shall begin no later than January 1, 2012. Agreements with an independence at home medical practice under the demonstration program may cover not more than a 10-year period.

(2) No physician duplication in demonstration participation

The Secretary shall not pay an independence at home medical practice under this section that participates in section 1395jjj of this title.

(3) No beneficiary duplication in demonstration participation

The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1395jjj of this title.

(4) Preference

In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

(A) located in high-cost areas of the country;

(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

(C) use electronic medical records, health information technology, and individualized plans of care.

(5) Limitation on number of practices

In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 20,000. An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth through tenth years of such program. An applicable beneficiary that participates in the demonstration program by reason of the increase from 15,000 to 20,000 in the first sentence of this paragraph pursuant to the amendment made by section 105 of division CC of the Consolidated Appropriations Act, 2021 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the eighth through tenth years of such program.

(6) Waiver

The Secretary may waive such provisions of this subchapter and subchapter XI as the Secretary determines necessary in order to implement the demonstration program.

(7) Administration

Chapter 35 of title 44 shall not apply to this section.

(f) Evaluation and monitoring

(1) In general

The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) Monitoring applicable beneficiaries

The Secretary may monitor data on expenditures and quality of services under this subchapter after an applicable beneficiary discontinues receiving services under this subchapter through a qualifying independence at home medical practice.

(g) Reports to Congress

The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program, including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi). Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this subchapter, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(h) Funding

For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this subchapter and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015 and $9,000,000 for fiscal year 2021. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Termination

(1) Mandatory termination

The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice did not achieve savings for the third of 3 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) Permissive termination

The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, §1866E, formerly §1866D, as added and renumbered §1866E, Pub. L. 111–148, title III, §3024, title X,

§ 10308(b)(2), Mar. 23, 2010, 124 Stat. 404, 942; amended Pub. L. 114–39, § 2, July 30, 2015, 129 Stat. 440; Pub. L. 115–123, div. E, title III, § 50301(a), Feb. 9, 2018, 132 Stat. 190; Pub. L. 116–260, div. CC, title I, § 105(a), Dec. 27, 2020, 134 Stat. 2944.)

Editorial Notes

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsecs. (c) and (d)(1)(A), (B), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

Section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act, referred to in subsec. (e)(5), probably means section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, div. E of Pub. L. 115–123, which amended this section.

Section 105 of division CC of the Consolidated Appropriations Act, 2021, referred to in subsec. (e)(5), is section 105 of div. CC of Pub. L. 116–260, which amended this section.

AMENDMENTS

2020—Subsec. (e)(1). Pub. L. 116–260, § 105(a)(1)(A), substituted ''10-year'' for ''7-year''.

Subsec. (e)(5). Pub. L. 116–260, § 105(a)(1)(B), substituted ''20,000'' for ''15,000'' in first sentence and ''sixth through tenth'' for ''sixth and seventh'' in second sentence and inserted at end ''An applicable beneficiary that participates in the demonstration program by reason of the increase from 15,000 to 20,000 in the first sentence of this paragraph pursuant to the amendment made by section 105 of division CC of the Consolidated Appropriations Act, 2021 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the eighth through tenth years of such program.''

Subsec. (h). Pub. L. 116–260, § 105(a)(2), inserted ''and $9,000,000 for fiscal year 2021'' after ''2015''.

2018—Subsec. (e)(1). Pub. L. 115–123, § 50301(a)(1)(A), substituted ''Agreements'' for ''An agreement'' and ''7-year'' for ''5-year''.

Subsec. (e)(5). Pub. L. 115–123, § 50301(a)(1)(B), substituted ''15,000'' for ''10,000'' and inserted at end ''An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program.''

Subsec. (g). Pub. L. 115–123, § 50301(a)(2), inserted '', including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)'' after ''under the demonstration program''.

Subsec. (i)(1)(A). Pub. L. 115–123, § 50301(a)(3), substituted ''did not achieve savings for the third of 3'' for ''will not receive an incentive payment for the second of 2''.

2015—Subsec. (e)(1). Pub. L. 114–39 substituted ''5-year'' for ''3-year''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, § 105(b), Dec. 27, 2020, 134 Stat. 2944, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of Public Law 111–148.''

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title III, § 50301(b), Feb. 9, 2018, 132 Stat. 190, provided that: ''The amendment made by subsection (a)(3) [amending this section] shall take effect as if included in the enactment of Public Law 111–148.''

§ 1395cc–6. Opioid use disorder treatment demonstration program

(a) Implementation of 4-year demonstration program

(1) In general

Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program under this subchapter (in this section referred to as the ''Program'') to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce expenditures under this subchapter. Under the Program, the Secretary shall make payments under subsection (e) to participants (as defined in subsection (c)(1)(A)) for furnishing opioid use disorder treatment services delivered through opioid use disorder care teams, or arranging for such services to be furnished, to applicable beneficiaries participating in the Program.

(2) Opioid use disorder treatment services

For purposes of this section, the term ''opioid use disorder treatment services''—

(A) means, with respect to an applicable beneficiary, services that are furnished for the treatment of opioid use disorders and that utilize drugs approved under section 355 of title 21 for the treatment of opioid use disorders in an outpatient setting; and

(B) includes—

(i) medication-assisted treatment;

(ii) treatment planning;

(iii) psychiatric, psychological, or counseling services (or any combination of such services), as appropriate;

(iv) social support services, as appropriate; and

(v) care management and care coordination services, including coordination with other providers of services and suppliers not on an opioid use disorder care team.

(b) Program design

(1) In general

The Secretary shall design the Program in such a manner to allow for the evaluation of the extent to which the Program accomplishes the following purposes:

(A) Reduces hospitalizations and emergency department visits.

(B) Increases use of medication-assisted treatment for opioid use disorders.

(C) Improves health outcomes of individuals with opioid use disorders, including by reducing the incidence of infectious diseases (such as hepatitis C and HIV).

(D) Does not increase the total spending on items and services under this subchapter.

(E) Reduces deaths from opioid overdose.

(F) Reduces the utilization of inpatient residential treatment.

(2) Consultation

In designing the Program, including the criteria under subsection (e)(2)(A), the Secretary shall, not later than 3 months after October 24, 2018, consult with specialists in the field of addiction, clinicians in the primary care community, and beneficiary groups.

(c) Participants; opioid use disorder care teams

(1) Participants

(A) Definition

In this section, the term ''participant'' means an entity or individual—

(i) that is otherwise enrolled under this subchapter and that is—

(I) a physician (as defined in section 1395x(r)(1) of this title);

(II) a group practice comprised of at least one physician described in subclause (I);

(III) a hospital outpatient department;

(IV) a federally qualified health center (as defined in section 1395x(aa)(4) of this title);

(V) a rural health clinic (as defined in section 1395x(aa)(2) of this title);

(VI) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title);

(VII) a clinic certified as a certified community behavioral health clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014; or

(VIII) any other individual or entity specified by the Secretary;

(ii) that applied for and was selected to participate in the Program pursuant to an application and selection process established by the Secretary; and

(iii) that establishes an opioid use disorder care team (as defined in paragraph (2)) through employing or contracting with health care practitioners described in paragraph (2)(A), and uses such team to furnish or arrange for opioid use disorder treatment services in the outpatient setting under the Program.

(B) Preference

In selecting participants for the Program, the Secretary shall give preference to individuals and entities that are located in areas with a prevalence of opioid use disorders that is higher than the national average prevalence.

(2) Opioid use disorder care teams

(A) In general

For purposes of this section, the term ''opioid use disorder care team'' means a team of health care practitioners established by a participant described in paragraph (1)(A) that—

(i) shall include—

(I) at least one physician (as defined in section 1395x(r)(1) of this title) furnishing primary care services or addiction treatment services to an applicable beneficiary; and

(II) at least one eligible practitioner (as defined in paragraph (3)), who may be a physician who meets the criterion in subclause (I); and

(ii) may include other practitioners licensed under State law to furnish psychiatric, psychological, counseling, and social services to applicable beneficiaries.

(B) Requirements for receipt of payment under program

In order to receive payments under subsection (e), each participant in the Program shall—

(i) furnish opioid use disorder treatment services through opioid use disorder care teams to applicable beneficiaries who agree to receive the services;

(ii) meet minimum criteria, as established by the Secretary; and

(iii) submit to the Secretary, in such form, manner, and frequency as specified by the Secretary, with respect to each applicable beneficiary for whom opioid use disorder treatment services are furnished by the opioid use disorder care team, data and such other information as the Secretary determines appropriate to—

(I) monitor and evaluate the Program;

(II) determine if minimum criteria are met under clause (ii); and

(III) determine the incentive payment under subsection (e).

(3) Eligible practitioner defined

For purposes of this section, the term ''eligible practitioner'' means a physician or other health care practitioner, such as a nurse practitioner, that—

(A) is enrolled under section 1395cc(j)(1) of this title;

(B) is authorized to prescribe or dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment; and

(C) has in effect a waiver in accordance with section 823(g) of title 21 for such purpose and is otherwise in compliance with regulations promulgated by the Substance Abuse and Mental Health Services Administration to carry out such section.

(d) Participation of applicable beneficiaries

(1) Applicable beneficiary defined

In this section, the term ''applicable beneficiary'' means an individual who—

(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C;

(C) has a current diagnosis for an opioid use disorder; and

(D) meets such other criteria as the Secretary determines appropriate.

Such term shall include an individual who is dually eligible for benefits under this subchapter and subchapter XIX if such individual satisfies the criteria described in subparagraphs (A) through (D).

(2) Voluntary beneficiary participation; limitation on number of beneficiaries

An applicable beneficiary may participate in the Program on a voluntary basis and may

terminate participation in the Program at any time. Not more than 20,000 applicable beneficiaries may participate in the Program at any time.

(3) Services

In order to participate in the Program, an applicable beneficiary shall agree to receive opioid use disorder treatment services from a participant. Participation under the Program shall not affect coverage of or payment for any other item or service under this subchapter for the applicable beneficiary.

(4) Beneficiary access to services

Nothing in this section shall be construed as encouraging providers to limit applicable beneficiary access to services covered under this subchapter, and applicable beneficiaries shall not be required to relinquish access to any benefit under this subchapter as a condition of receiving services from a participant in the Program.

(e) Payments

(1) Per applicable beneficiary per month care management fee

(A) In general

The Secretary shall establish a schedule of per applicable beneficiary per month care management fees. Such a per applicable beneficiary per month care management fee shall be paid to a participant in addition to any other amount otherwise payable under this subchapter to the health care practitioners in the participant's opioid use disorder care team or, if applicable, to the participant. A participant may use such per applicable beneficiary per month care management fee to deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under this subchapter.

(B) Payment amounts

In carrying out subparagraph (A), the Secretary may—

(i) consider payments otherwise payable under this subchapter for opioid use disorder treatment services and the needs of applicable beneficiaries;

(ii) pay a higher per applicable beneficiary per month care management fee for an applicable beneficiary who receives more intensive treatment services from a participant and for whom those services are appropriate based on clinical guidelines for opioid use disorder care;

(iii) pay a higher per applicable beneficiary per month care management fee for the month in which the applicable beneficiary begins treatment with a participant than in subsequent months, to reflect the greater time and costs required for the planning and initiation of treatment, as compared to maintenance of treatment; and

(iv) take into account whether a participant's opioid use disorder care team refers applicable beneficiaries to other suppliers or providers for any opioid use disorder treatment services.

(C) No duplicate payment

The Secretary shall make payments under this paragraph to only one participant for services furnished to an applicable beneficiary during a calendar month.

(2) Incentive payments

(A) In general

Under the Program, the Secretary shall establish a performance-based incentive payment, which shall be paid (using a methodology established and at a time determined appropriate by the Secretary) to participants based on the performance of participants with respect to criteria, as determined appropriate by the Secretary, in accordance with subparagraph (B).

(B) Criteria

(i) In general

Criteria described in subparagraph (A) may include consideration of the following:

(I) Patient engagement and retention in treatment.

(II) Evidence-based medication-assisted treatment.

(III) Other criteria established by the Secretary.

(ii) Required consultation and consideration

In determining criteria described in subparagraph (A), the Secretary shall—

(I) consult with stakeholders, including clinicians in the primary care community and in the field of addiction medicine; and

(II) consider existing clinical guidelines for the treatment of opioid use disorders.

(C) No duplicate payment

The Secretary shall ensure that no duplicate payments under this paragraph are made with respect to an applicable beneficiary.

(f) Multipayer strategy

In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applied under the Program under subsection (e)(2)(C). The Secretary may enter into a memorandum of understanding with other payers to align the methodology for payment provided by such a payer related to opioid use disorder treatment services with such methodology for payment under the Program.

(g) Evaluation

(1) In general

The Secretary shall conduct an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program.

(2) Reports

The Secretary shall submit to Congress—

(A) a report with respect to the intermediate evaluation under paragraph (1) not

later than 3 years after the date of the implementation of the Program; and

(B) a report with respect to the final evaluation under paragraph (1) not later than 6 years after such date.

(h) Funding

(1) Administrative funding

For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), $5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(2) Care management fees and incentives

For the purposes of making payments under subsection (e), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title for each of fiscal years 2021 through 2024.

(3) Availability

Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Waivers

The Secretary may waive any provision of this subchapter as may be necessary to carry out the Program under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1866F, as added Pub. L. 115–271, title VI, §6042, Oct. 24, 2018, 132 Stat. 3979.)

Editorial Notes

REFERENCES IN TEXT

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (c)(1)(A)(i)(VII), is section 223 of Pub. L. 113–93, which is set out as a note under section 1396a of this title.

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

[1] So in original. Probably should be followed by a comma.

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term ''emergency medical condition'' means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term ''participating hospital'' means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term ''to stabilize'' means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term ''stabilized'' means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term ''transfer'' means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term ''hospital'' includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1867, as added Pub. L. 99–272, title IX, § 9121(b), Apr. 7, 1986, 100

Stat. 164; amended Pub. L. 99–509, title IX, § 9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 99–514, title XVIII, § 1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, § 4009(a)(1), formerly § 4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330–56, 1330–57; Pub. L. 100–360, title IV, § 411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub. L. 100–485, title VI, § 608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–239, title VI, §§ 6003(g)(3)(D)(xiv), 6211(a)–(h), Dec. 19, 1989, 103 Stat. 2154, 2245–2248; Pub. L. 101–508, title IV, §§ 4008(b)(1)–(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388–44, 1388–117, 1388–124, renumbered and amended Pub. L. 103–432, title I, § 160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–33, title IV, § 4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, § 736(a)(14), title IX, § 944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423; Pub. L. 112–40, title II, § 261(a)(3)(A), (E), Oct. 21, 2011, 125 Stat. 423; Pub. L. 116–260, div. CC, title I, § 125(b)(2)(B), Dec. 27, 2020, 134 Stat. 2966.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(b)(2)(B) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment note below.

Editorial Notes

PRIOR PROVISIONS

A prior section 1395dd, act Aug. 14, 1935, ch. 531, title XVIII, § 1867, as added July 30, 1965, Pub. L. 89–97, title I, § 102(a), 79 Stat. 329; amended Jan. 2, 1968, Pub. L. 90–248, title I, § 164(a), 81 Stat. 873; Oct. 30, 1972, Pub. L. 92–603, title II, § 288, 86 Stat. 1457, related to creation, composition, meetings, and functions of the Health Insurance Benefits Advisory Council and the appointment of a Chairman and members thereto, and qualifications, terms of office, compensation, and reimbursement of travel expenses of members, prior to repeal by Pub. L. 98–369, div. B, title III, § 2349(a), July 18, 1984, 98 Stat. 1097, eff. July 18, 1984.

AMENDMENTS

2020—Subsec. (e)(5). Pub. L. 116–260 inserted ''and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title)'' before period at end.

2011—Subsec. (d)(3). Pub. L. 112–40 substituted ''quality improvement'' for ''peer review'' in heading and for ''utilization and quality control peer review'' in text.

2003—Subsec. (d)(1)(B). Pub. L. 108–173, § 736(a)(14)(A), substituted ''if the violation is'' for ''if the violation is is'' in concluding provisions.

Subsec. (d)(3). Pub. L. 108–173, § 944(c)(1), inserted ''or in terminating a hospital's participation under this subchapter'' after ''in imposing sanctions under paragraph (1)'' and inserted at end ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''

Subsec. (d)(4). Pub. L. 108–173, § 944(b), added par. (4).

Subsec. (e)(1)(B). Pub. L. 108–173, § 736(a)(14)(B), substituted ''a pregnant woman'' for ''a pregnant women''.

Subsec. (e)(2). Pub. L. 108–173, § 736(a)(14)(C), substituted ''means a hospital'' for ''means hospital''.

1997—Subsec. (e)(5). Pub. L. 105–33 substituted ''critical access'' for ''rural primary care''.

1994—Subsec. (d)(3). Pub. L. 103–432, § 160(d)(5)(A), made technical amendment to Pub. L. 101–508, § 4207(a)(1)(A). See 1990 Amendment note below.

1990—Subsec. (c)(2)(C). Pub. L. 101–508, § 4008(b)(3)(A)(iii), substituted ''subsection (d)(1)(C)'' for ''subsection (d)(2)(C)''.

Subsec. (d)(1). Pub. L. 101–508, § 4008(b)(3)(A)(i), (ii), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: ''If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

''(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

''(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.''

Subsec. (d)(1)(B). Pub. L. 101–508, § 4207(a)(2), (3), formerly § 4027(a)(2), (3), as renumbered by Pub. L. 103–432, § 160(d)(4), which directed amendment of par. (2)(B) by substituting ''negligently'' for ''knowingly'' and ''is gross and flagrant or is repeated'' for ''knowing and willful or negligent'', was executed by making the substitutions in par. (1)(B) to reflect the probable intent of Congress and the intervening redesignation of par. (2) as (1) by Pub. L. 101–508, § 4008(b)(3)(A)(ii). See above.

Subsec. (d)(2). Pub. L. 101–508, § 4008(b)(3)(A)(ii), redesignated par. (3) as (2). Former par. (2) redesignated (1).

Subsec. (d)(2)(A). Pub. L. 101–508, § 4008(b)(1), (2), substituted ''negligently'' for ''knowingly'' and inserted ''(or not more than $25,000 in the case of a hospital with less than 100 beds)'' after ''$50,000''.

Subsec. (d)(3). Pub. L. 101–508, § 4207(a)(1)(A), formerly § 4027(a)(1)(A), as renumbered and amended by Pub. L. 103–432, § 160(d)(4), (5)(A), added par. (3). Former par. (3) redesignated (2).

Subsec. (i). Pub. L. 101–508, § 4207(k)(3), formerly § 4027(k)(3), as renumbered by Pub. L. 103–432, § 160(d)(4), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: ''A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.''

1989—Pub. L. 101–239, § 6211(h)(2)(A), struck out ''active'' before ''labor'' in section catchline.

Subsec. (a). Pub. L. 101–239, § 6211(h)(2)(B), which directed the amendment of subsec. (a) by striking out ''or to determine if the individual is in active labor (within the meaning of section (e)(2))'' was executed by striking out ''or to determine if the individual is in active labor (within the meaning of subsection (e)(2))'' after ''exists''.

Pub. L. 101–239, § 6211(a), substituted ''hospital's emergency department, including ancillary services routinely available to the emergency department,'' for ''hospital's emergency department''.

Subsec. (b). Pub. L. 101–239, § 6211(h)(2)(C), struck out ''active'' before ''labor'' in heading.

Subsec. (b)(1). Pub. L. 101–239, § 6211(h)(2)(D)(i), struck out ''or is in active labor'' after ''emergency medical condition'' in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 101–239, § 6211(h)(2)(D)(ii), struck out ''or to provide for treatment of the labor'' after ''stabilize the medical condition''.

Subsec. (b)(2). Pub. L. 101–239, § 6211(b)(1), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,'' after ''in that paragraph'', substituted ''and treatment.'' for ''or treatment.'', and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.''

Subsec. (b)(3). Pub. L. 101–239, § 6211(b)(2), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the in-

dividual of such transfer,'' after ''subsection (c)'' and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.''

Subsec. (c). Pub. L. 101–239, §6211(g)(1)(A), substituted ''individual'' for ''patient'' in heading.

Subsec. (c)(1). Pub. L. 101–239, §6211(c)(4), (g)(1)(B), (h)(2)(E), in introductory provisions, substituted ''an individual'' for ''a patient'', ''subsection (e)(3)(B))'' for ''subsection (e)(4)(B)) or is in active labor'', and ''the individual'' for ''the patient'', and inserted at end ''A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.''

Subsec. (c)(1)(A)(i). Pub. L. 101–239, §6211(c)(1), (g)(1)(B), substituted ''the individual'' for ''the patient'', ''the individual's behalf'' for ''the patient's behalf'', and ''after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility'' for ''requests that the transfer be effected''.

Subsec. (c)(1)(A)(ii). Pub. L. 101–239, §6211(c)(2)(B), (3), (g)(1)(B), substituted ''has signed a certification that based upon the information available at the time of transfer'' for '', or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time'' and ''individual and, in the case of labor, to the unborn child'' for ''individual's medical condition''.

Subsec. (c)(1)(A)(iii). Pub. L. 101–239, §6211(c)(2)(A), (C), (D), added cl. (iii).

Subsec. (c)(2)(A). Pub. L. 101–239, §6211(c)(5), added subpar. (A). Former subpar. (A) redesignated (B).

Subsec. (c)(2)(B). Pub. L. 101–239, §6211(c)(5)(A), (g)(1)(B), redesignated subpar. (A) as (B) and substituted ''the individual'' for ''the patient'' in cls. (i) and (ii). Former subpar. (B) redesignated (C).

Subsec. (c)(2)(C). Pub. L. 101–239, §6211(c)(5)(A), (d), redesignated subpar. (B) as (C) and substituted ''sends to'' for ''provides'' and ''all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment'' for ''with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital''. Former subpar. (C) redesignated (D).

Subsec. (c)(2)(D). Pub. L. 101–239, §6211(c)(5)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 101–239, §6211(c)(5)(A), (g)(1)(B), redesignated subpar. (D) as (E) and substituted ''individuals'' for ''patients''.

Subsec. (d)(2)(B). Pub. L. 101–239, §6211(e)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.''

Subsec. (d)(2)(C). Pub. L. 101–239, §6211(e)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: ''As used in this paragraph, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

''(i) is employed by, or under contract with, the participating hospital, and

''(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.''

Subsec. (e)(1). Pub. L. 101–239, §6211(h)(1)(A), substituted ''means—'' and subpars. (A) and (B) for ''means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

''(A) placing the patient's health in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.''

Subsec. (e)(2). Pub. L. 101–239, §6211(h)(1)(B), (E), redesignated par. (3) as (2) and struck out former par. (2) which defined ''active labor''.

Subsec. (e)(3). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (4) as (3). Former par. (3) redesignated (2).

Subsec. (e)(4). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(4)(A). Pub. L. 101–239, §6211(h)(1)(C), substituted ''emergency medical condition described in paragraph (1)(A)'' for ''emergency medical condition'', ''likely to result from or occur during'' for ''likely to result from'', and ''from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)'' for ''from a facility''.

Subsec. (e)(4)(B). Pub. L. 101–239, §6211(h)(1)(D), inserted ''described in paragraph (1)(A)'' after ''emergency medical condition'', ''or occur during'' after ''to result from'', and '', or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)'' after ''from a facility''.

Subsec. (e)(5). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Pub. L. 101–239, §6211(g)(2), substituted ''an individual'' for ''a patient'' in two places.

Subsec. (e)(6). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5).

Pub. L. 101–239, §6003(g)(3)(D)(xiv), added par. (6).

Subsecs. (g) to (i). Pub. L. 101–239, §6211(f), added subsecs. (g) to (i).

1988—Subsec. (d)(1). Pub. L. 100–360, §411(b)(8)(A)(i), amended Pub. L. 100–203, §4009(a)(2), see 1987 Amendment note below.

Subsec. (d)(2). Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), amended Pub. L. 100–203, §4009(a)(1), see 1987 Amendment note below.

1987—Subsec. (d)(1). Pub. L. 100–203, §4009(a)(2), which directed insertion of a provision related to imposing the sanction described in section 1395u(j)(2)(A) of this title, was amended generally by Pub. L. 100–360, §411(b)(8)(A)(i), so that it does not amend par. (1).

Subsec. (d)(2). Pub. L. 100–203, §4009(a)(1), as amended by Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), substituted subpars. (A) and (B) for ''In addition to the other grounds for imposition of a civil money penalty under section 1320a–7a(a) of this title, a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation.'', designated second sentence as subpar. (C), substituted ''this paragraph'' for ''the previous sentence'', and redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (C).

1986—Subsec. (b)(2), (3). Pub. L. 99–509 struck out ''legally responsible'' after ''individual (or a''.

Subsec. (e)(3). Pub. L. 99–514 struck out ''and has, under the agreement, obligated itself to comply with the requirements of this section'' after ''section 1395cc of this title''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 944(c)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to terminations of participation initiated on or after the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(b)(1)–(3)(A) of Pub. L. 101–508 applicable to actions occurring on or after the first day of the sixth month beginning after Nov. 5, 1990, see section 4008(b)(4) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

Amendment by section 4207(a)(1)(A) of Pub. L. 101–508 effective on the first day of the first month beginning more than 60 days after Nov. 5, 1990, see section 4207(a)(1)(C) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

Pub. L. 101–508, title IV, § 4207(a)(4), formerly § 4027(a)(4), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered and amended by Pub. L. 103–432, title I, § 160(d)(4), (5)(B), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by paragraphs (2) and (3) [amending this section] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6211(i), Dec. 19, 1989, 103 Stat. 2249, provided that: ''The amendments made by this section [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date.''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4009(a)(2), formerly § 4009(a)(3), Dec. 22, 1987, 101 Stat. 1330–57, as redesignated by Pub. L. 100–360, title IV, § 411(b)(8)(A)(ii), July 1, 1988, 102 Stat. 772, provided that: ''The amendments made by this subsection [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

EFFECTIVE DATE

Pub. L. 99–272, title IX, § 9121(c), Apr. 7, 1986, 100 Stat. 167, provided that: ''The amendments made by this section [enacting this section and amending section 1395cc of this title] shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act [Apr. 7, 1986].''

SHORT TITLE

This section is popularly known as the Emergency Medical Treatment and Labor Act (EMTALA).

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP

Pub. L. 108–173, title IX, § 945, Dec. 8, 2003, 117 Stat. 2423, provided that:

''(a) ESTABLISHMENT.—The Secretary [of Health and Human Services] shall establish a Technical Advisory Group (in this section referred to as the 'Advisory Group') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term 'EMTALA' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

''(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

''(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

''(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

''(3) 2 shall represent patients;

''(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

''(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

''(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

''(1) shall review EMTALA regulations;

''(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

''(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

''(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

''(d) ADMINISTRATIVE MATTERS.—

''(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

''(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

''(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

''(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).''

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Pub. L. 108–173, title X, §1011, Dec. 8, 2003, 117 Stat. 2432, provided that:

''(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary [of Health and Human Services] $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

''(b) STATE ALLOTMENTS.—

''(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

''(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

''(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

''(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

''(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

''(c) USE OF FUNDS.—

''(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

''(2) DETERMINATION OF PAYMENT AMOUNTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

''(i) the amount that the provider demonstrates was incurred for the provision of such services; or

''(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

''(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

''(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

''(A) may establish different methodologies for types of eligible providers;

''(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

''(C) shall provide for the election by a hospital to receive either payments to the hospital for—

''(i) hospital and physician services; or

''(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

''(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

''(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

''(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

''(A) Undocumented aliens.

''(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

''(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a 'laser visa') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

''(d) APPLICATIONS; ADVANCE PAYMENTS.—

''(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

''(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

''(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

''(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1)

may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE PROVIDER.—The term 'eligible provider' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

''(2) ELIGIBLE SERVICES.—The term 'eligible services' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

''(3) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

''(4) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

''(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(6) STATE.—The term 'State' means the 50 States and the District of Columbia.''

INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS

Pub. L. 101–508, title IV, §4008(c), Nov. 5, 1990, 104 Stat. 1388–44, directed Secretary of Health and Human Services (acting through Inspector General of Department of Health and Human Services) to conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act (this section) relating to the examination and treatment of individuals with an emergency medical condition and women in labor, with Secretary to submit a report to Congress on the study not later than 1 year after Nov. 5, 1990.

Executive Documents

EX. ORD. NO. 13952. PROTECTING VULNERABLE NEWBORN AND INFANT CHILDREN

Ex. Ord. No. 13952, Sept. 25, 2020, 85 F.R. 62187, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Every infant born alive, no matter the circumstances of his or her birth, has the same dignity and the same rights as every other individual and is entitled to the same protections under Federal law. Such laws include the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, which guarantees, in hospitals that have an emergency department, each individual's right to an appropriate medical screening examination and to either stabilizing treatment or an appropriate transfer. They also include section 504 of the Rehabilitation Act [of 1973] (Rehab Act), 29 U.S.C. 794, which prohibits discrimination against individuals with disabilities by programs and activities receiving Federal funding. In addition, the Born-Alive Infants Protection Act [of 2002], 1 U.S.C. 8, makes clear that all infants born alive are individuals for purposes of these and other Federal laws and are therefore afforded the same legal protections as any other person. Together, these laws help protect infants born alive from discrimination in the provision of medical treatment, including infants who require emergency medical treatment, who are premature, or who are born with disabilities. Such infants are entitled to meaningful and non-discriminatory access to medical examination and services, with the consent of a parent or guardian, when they present at hospitals receiving Federal funds.

Despite these laws, some hospitals refuse the required medical screening examination and stabilizing treatment or otherwise do not provide potentially lifesaving medical treatment to extremely premature or disabled infants, even when parents plead for such treatment. Hospitals might refuse to provide treatment to extremely premature infants—born alive before 24 weeks of gestation—because they believe these infants may not survive, may have to live with long-term disabilities, or may have a quality-of-life deemed to be inadequate. Active treatment of extremely premature infants has, however, been shown to improve their survival rates. And the denial of such treatment, or discouragement of parents from seeking such treatment for their children, devalues the lives of these children and may violate Federal law.

SEC. 2. *Policy*. It is the policy of the United States to recognize the human dignity and inherent worth of every newborn or other infant child, regardless of prematurity or disability, and to ensure for each child due protection under the law.

SEC. 3. (a) The Secretary of Health and Human Services (Secretary) shall ensure that individuals responsible for all programs and activities under his jurisdiction that receive Federal funding are aware of their obligations toward infants, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment, under EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act. In particular, the Secretary shall ensure that individuals responsible for such programs and activities are aware that they are not excused from complying with these obligations, including the obligation to provide an appropriate medical screening examination and stabilizing treatment or transfer, when extremely premature infants are born alive or infants are born with disabilities. The Secretary shall also ensure that individuals responsible for such programs and activities are aware that they may not unlawfully discourage parents from seeking medical treatment for their infant child solely because of their infant child's disability. The Secretary shall further ensure that individuals responsible for such programs and activities are aware of their obligations to provide stabilizing treatment that will allow the infant patients to be transferred to a more suitable facility if appropriate treatment is not possible at the initial location.

(b) The Secretary shall, as appropriate and consistent with applicable law, ensure that Federal funding disbursed by the Department of Health and Human Services is expended in full compliance with EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act, as reflected in the policy set forth in section 2 of this order.

(i) The Secretary shall, as appropriate and to the fullest extent permitted by law, investigate complaints of violations of applicable Federal laws with respect to infants born alive, including infants who have an emergency medical condition in need of stabilizing treatment or infants with disabilities whose parents seek medical treatment for their infants. The Secretary shall also clarify, in an easily understandable format, the process by which parents and hospital staff may submit such complaints for investigation under applicable Federal laws.

(ii) The Secretary shall take all appropriate enforcement action against individuals and organizations found through investigation to have violated applicable

Federal laws, up to and including terminating Federal funding for non-compliant programs and activities.

(c) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding and National Institutes of Health research dollars for programs and activities conducting research to develop treatments that may improve survival—especially survival without impairment—of infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(d) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding to programs and activities, including hospitals, that provide training to medical personnel regarding the provision of life-saving medical treatment to all infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(e) The Secretary shall, as necessary and consistent with applicable law, issue such regulations or guidance as may be necessary to implement this order.

SEC. 4. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395ee. Practicing Physicians Advisory Council; Council for Technology and Innovation

(a) Repealed. Pub. L. 111–148, title III, § 3134(b)(2), Mar. 23, 2010, 124 Stat. 435

(b) Council for Technology and Innovation

(1) Establishment

The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'').

(2) Composition

The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) Duties

The Council shall coordinate the activities of coverage, coding, and payment processes under this subchapter with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) Executive Coordinator for Technology and Innovation

The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this subchapter.

(c) Physician-focused payment models

(1) Technical Advisory Committee

(A) Establishment

There is established an ad hoc committee to be known as the ''Physician-Focused Payment Model Technical Advisory Committee'' (referred to in this subsection as the ''Committee'').

(B) Membership

(i) Number and appointment

The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

(ii) Qualifications

The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

(iii) Prohibition on Federal employment

A member of the Committee shall not be an employee of the Federal Government.

(iv) Ethics disclosure

The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(v) Date of initial appointments

The initial appointments of members of the Committee shall be made by not later than 180 days after April 16, 2015.

(C) Term; vacancies

(i) Term

The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(ii) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

(D) Duties

The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

(E) Compensation of members

(i) In general

Except as provided in clause (ii), a member of the Committee shall serve without compensation.

(ii) Travel expenses

A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5 while away from the home or regular place of business of the member in the performance of the duties of the Committee.

(F) Operational and technical support

(i) In general

The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

(ii) Funding

The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, such amounts as are necessary to carry out this paragraph (not to exceed $5,000,000) for fiscal year 2015 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

(G) Application

Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

(2) Criteria and process for submission and review of physician-focused payment models

(A) Criteria for assessing physician-focused payment models

(i) Rulemaking

Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

(ii) MedPAC submission of comments

During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iii) Updating

The Secretary may update the criteria established under this subparagraph through rulemaking.

(B) Stakeholder submission of physician-focused payment models

On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

(C) Committee review of models submitted

The Committee, on a periodic basis—

(i) shall review models submitted under subparagraph (B);

(ii) may provide individuals and stakeholder entities who submitted such models with—

(I) initial feedback on such models regarding the extent to which such models meet the criteria described in subparagraph (A); and

(II) an explanation of the basis for the feedback provided under subclause (I); and

(iii) shall prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A) and submit such comments and recommendations to the Secretary.

(D) Secretary review and response

The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

(3) Rule of construction

Nothing in this subsection shall be construed to impact the development or testing of models under this subchapter or subchapters XI, XIX, or XXI.

(Aug. 14, 1935, ch. 531, title XVIII, § 1868, as added Pub. L. 101–508, title IV, § 4112, Nov. 5, 1990, 104 Stat. 1388–64; amended Pub. L. 108–173, title IX, § 942(a), Dec. 8, 2003, 117 Stat. 2420; Pub. L. 111–148, title III, § 3134(b)(2), Mar. 23, 2010, 124 Stat. 435; Pub. L. 114–10, title I, § 101(e)(1), Apr. 16, 2015, 129 Stat. 115; Pub. L. 115–123, div. E, title X, § 51003(b), Feb. 9, 2018, 132 Stat. 295.)

Editorial Notes

REFERENCES IN TEXT

The Ethics in Government Act of 1978, referred to in subsec. (c)(1)(B)(iv), is Pub. L. 95–521, Oct. 26, 1978, 92 Stat. 1824. Title I of the Act is set out in the Appendix to Title 5, Government Organization and Employees. For complete classification of this Act to the Code, see Short Title note set out under section 101 of Pub. L. 95–521 in the Appendix to Title 5 and Tables.

Section 14 of the Federal Advisory Committee Act, referred to in subsec. (c)(1)(G), is section 14 of Pub. L. 92–463, which is set out in the Appendix to Title 5, Government Organization and Employees.

PRIOR PROVISIONS

A prior section 1395ee, act Aug. 14, 1935, ch. 531, title XVIII, § 1868, as added July 30, 1965, Pub. L. 89–97, title

I, §102(a), 79 Stat. 329, provided for creation of a National Medical Review Committee, functions of such Committee, including submission of annual reports to the Secretary and Congress, employment of technical assistance, and for availability of assistance and data, prior to repeal by Pub. L. 90–248, title I, §164(c), Jan. 2, 1968, 81 Stat. 874.

AMENDMENTS

2018—Subsec. (c)(2)(C). Pub. L. 115–123 amended subpar. (C) generally. Prior to amendment, text read as follows: ''The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.''

2015—Subsec. (c). Pub. L. 114–10 added subsec. (c).

2010—Subsec. (a). Pub. L. 111–148 struck out subsec. (a) which related to the Practicing Physicians Advisory Council.

2003—Pub. L. 108–173, §942(a)(1), inserted ''; Council for Technology and Innovation'' in section catchline.

Subsec. (a). Pub. L. 108–173, §942(a)(2)–(4), inserted subsec. heading, redesignated existing provisions as par. (1), substituted ''in this subsection'' for ''in this section'', and redesignated former subsecs. (b) and (c) as pars. (2) and (3), respectively.

Subsec. (b). Pub. L. 108–173, §942(a)(5), added subsec. (b). Former subsec. (b) redesignated par. (2) of subsec. (a).

Subsec. (c). Pub. L. 108–173, §942(a)(4), redesignated subsec. (c) as par. (3) of subsec. (a).

Statutory Notes and Related Subsidiaries

TERMINATION OF ADVISORY COUNCILS

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by Congress, its duration is otherwise provided by law. See sections 3(2) and 14 of Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, 776, set out in the Appendix to Title 5, Government Organization and Employees.

§ 1395ff. Determinations; appeals

(a) Initial determinations

(1) Promulgations of regulations

The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

(A) The initial determination of whether an individual is entitled to benefits under such parts.

(B) The initial determination of the amount of benefits available to the individual under such parts.

(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a quality improvement organization under section 1320c–3(a)(2) of this title, and an initial determination made by an entity pursuant to a contract (other than a contract under section 1395w–22 of this title) with the Secretary to administer provisions of this subchapter or subchapter XI.

(2) Deadlines for making initial determinations

(A) In general

Subject to subparagraph (B), in promulgating regulations under paragraph (1), initial determinations shall be concluded by not later than the 45-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a claim for benefits from an individual as described in paragraph (1). Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 45-day period.

(B) Clean claims

Subparagraph (A) shall not apply with respect to any claim that is subject to the requirements of section 1395h(c)(2) or 1395u(c)(2) of this title.

(3) Redeterminations

(A) In general

In promulgating regulations under paragraph (1) with respect to initial determinations, such regulations shall provide for a fiscal intermediary or a carrier to make a redetermination with respect to a claim for benefits that is denied in whole or in part.

(B) Limitations

(i) Appeal rights

No initial determination may be reconsidered or appealed under subsection (b) unless the fiscal intermediary or carrier has made a redetermination of that initial determination under this paragraph.

(ii) Decisionmaker

No redetermination may be made by any individual involved in the initial determination.

(C) Deadlines

(i) Filing for redetermination

A redetermination under subparagraph (A) shall be available only if notice is filed with the Secretary to request the redetermination by not later than the end of the 120-day period beginning on the date the individual receives notice of the initial determination under paragraph (2).

(ii) Concluding redeterminations

Redeterminations shall be concluded by not later than the 60-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a request for a redetermination. Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 60-day period.

(D) Construction

For purposes of the succeeding provisions of this section a redetermination under this paragraph shall be considered to be part of the initial determination.

(4) Requirements of notice of determinations

With respect to an initial determination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the determination shall include—

(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

(5) Requirements of notice of redeterminations

With respect to a redetermination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the redetermination shall include—

(i) the specific reasons for the redetermination;

(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

(b) Appeal rights

(1) In general

(A) Reconsideration of initial determination

Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and, subject to paragraph (2), to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title. For purposes of the preceding sentence, any reference to the ''Commissioner of Social Security'' or the ''Social Security Administration'' in subsection (g) or (*l*) of section 405 of this title shall be considered a reference to the ''Secretary'' or the ''Department of Health and Human Services'', respectively.

(B) Representation by provider or supplier

(i) In general

Sections 406(a), 1302, and 1395hh of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

(ii) Mandatory waiver of right to payment from beneficiary

Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1395pp(a)(2) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

(iii) Prohibition on payment for representation

If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

(iv) Requirements for representatives of a beneficiary

The provisions of section 405(j) of this title and of section 406 of this title (other than subsection (a)(4) of such section) regarding representation of claimants shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

(C) Succession of rights in cases of assignment

The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

(D) Time limits for filing appeals

(i) Reconsiderations

Reconsideration under subparagraph (A) shall be available only if the individual described in subparagraph (A) files notice with the Secretary to request reconsideration by not later than the end of the 180-day period beginning on the date the individual receives notice of the redetermination under subsection (a)(3), or within such additional time as the Secretary may allow.

(ii) Hearings conducted by the Secretary

The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 405 and 406 of this title.

(E) Amounts in controversy

(i) In general

A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

(ii) Aggregation of claims

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more appeals to be aggregated if the appeals involve—

(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

(II) common issues of law and fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

(iii) Adjustment of dollar amounts

For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(F) Expedited proceedings

(i) Expedited determination

In the case of an individual who has received notice from a provider of services that such provider plans—

(I) to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

(II) to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

(ii) Reference to expedited access to judicial review

For the provision relating to expedited access to judicial review, see paragraph (2).

(G) Reopening and revision of determinations

The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

(2) Expedited access to judicial review

(A) In general

The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

(B) Prompt determinations

If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(C) Access to judicial review

(i) In general

If the appropriate review entity—

(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

(II) fails to make such determination within the period provided under subparagraph (B),

then the appellant may bring a civil action as described in this subparagraph.

(ii) Deadline for filing

Such action shall be filed, in the case described in—

(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) Venue

Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

(iv) Interest on any amounts in controversy

Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this subchapter.

(D) Review entity defined

For purposes of this subsection, the term ''review entity'' means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.

(3) Requiring full and early presentation of evidence by providers

A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

(c) Conduct of reconsiderations by independent contractors

(1) In general

The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under subparagraphs (B) and (C) of subsection (a)(1). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

(2) Qualified independent contractor

For purposes of this subsection, the term ''qualified independent contractor'' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a)(1), and that meets the requirements established by the Secretary consistent with paragraph (3).

(3) Requirements

Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet all of the following requirements:

(A) In general

The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required by the Secretary to carry out the provisions of this subsection, and shall have sufficient medical, legal, and other expertise (including knowledge of the program under this subchapter) and sufficient staffing to make reconsiderations under this subsection.

(B) Reconsiderations

(i) In general

The qualified independent contractor shall review initial determinations. Where an initial determination is made with respect to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1395y(a)(1)(A) of this title), such review shall include consideration of the facts and circumstances of the initial determination by a panel of physicians or other appropriate health care professionals and any decisions with respect to the reconsideration shall be based on applicable information, including clinical experience (including the medical records of the individual involved) and medical, technical, and scientific evidence.

(ii) Effect of national and local coverage determinations

(I) National coverage determinations

If the Secretary has made a national coverage determination pursuant to the requirements established under the third sentence of section 1395y(a) of this title, such determination shall be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section.

(II) Local coverage determinations

If the Secretary has made a local coverage determination, such determination shall not be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section. Notwithstanding the previous sentence, the qualified independent contractor shall consider the local coverage determination in making such decision.

(III) Absence of national or local coverage determination

In the absence of such a national coverage determination or local coverage determination, the qualified independent contractor shall make a decision with respect to the reconsideration based on applicable information, including clinical experience and medical, technical, and scientific evidence.

(C) Deadlines for decisions

(i) Reconsiderations

Except as provided in clauses (iii) and (iv), the qualified independent contractor

shall conduct and conclude a reconsideration under subparagraph (B), and mail the notice of the decision with respect to the reconsideration by not later than the end of the 60-day period beginning on the date a request for reconsideration has been timely filed.

(ii) Consequences of failure to meet deadline

In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i) or to provide notice by the end of the period described in clause (iii), as the case may be, the party requesting the reconsideration or appeal may request a hearing before the Secretary, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

(iii) Expedited reconsiderations

The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) as follows:

(I) Deadline for decision

Notwithstanding section 416(j) of this title and subject to clause (iv), not later than the end of the 72-hour period beginning on the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

(II) Consultation with beneficiary

In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

(III) Special rule for hospital discharges

A reconsideration of a discharge from a hospital shall be conducted under this clause in accordance with the provisions of paragraphs (2), (3), and (4) of section 1320c–3(e) of this title as in effect on the date that precedes December 21, 2000.

(iv) Extension

An individual requesting a reconsideration under this subparagraph may be granted such additional time as the individual specifies (not to exceed 14 days) for the qualified independent contractor to conclude the reconsideration. The individual may request such additional time orally or in writing.

(D) Qualifications for reviewers

The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).

(E) Explanation of decision

Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing, be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate) and shall include[1] a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision, and[2] a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section[3] and[3] in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1395y(a)(1)(A) of this title)[3] an explanation of the medical and scientific rationale for the decision.

(F) Notice requirements

Whenever a qualified independent contractor makes a decision with respect to a reconsideration under this subsection, the qualified independent contractor shall promptly notify the entity responsible for the payment of claims under part A or part B of such decision.

(G) Dissemination of decisions on reconsiderations

Each qualified independent contractor shall make available all decisions with respect to reconsiderations of such qualified independent contractors to fiscal intermediaries (under section 1395h of this title), carriers (under section 1395u of this title), quality improvement organizations (under part B of subchapter XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, other entities under contract with the Secretary to make initial determinations under part A or part B or subchapter XI, and to the public. The Secretary shall establish a methodology under which qualified independent contractors shall carry out this subparagraph.

(H) Ensuring consistency in decisions

Each qualified independent contractor shall monitor its decisions with respect to reconsiderations to ensure the consistency of such decisions with respect to requests for reconsideration of similar or related matters.

(I) Data collection

(i) In general

Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such informa-

[1] So in original.

[2] So in original. The word ''and'' probably should not appear.

[3] So in original. A comma probably should appear.

tion and records as the Secretary may require for such purposes.

(ii) Type of data collected

Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

(I) Specific claims that give rise to appeals.

(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

(III) Situations suggesting the need for changes in national or local coverage determination.

(IV) Situations suggesting the need for changes in local coverage determinations.

(iii) Annual reporting

Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

(J) Hearings by the Secretary

The qualified independent contractor shall (i) submit such information as is required for an appeal of a decision of the contractor, and (ii) participate in such hearings as required by the Secretary.

(K) Independence requirements

(i) In general

Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

(I) is not a related party (as defined in subsection (g)(5));

(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(III) does not otherwise have a conflict of interest with such a party.

(ii) Exception for reasonable compensation

Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(iii) Limitations on entity compensation

Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

(4) Number of qualified independent contractors

The Secretary shall enter into contracts with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection.

(5) Limitation on qualified independent contractor liability

No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(d) Deadlines for hearings by the Secretary; notice

(1) Hearing by administrative law judge

(A) In general

Except as provided in subparagraph (B), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

(B) Waiver of deadline by party seeking hearing

The 90-day period under subparagraph (A) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

(2) Departmental Appeals Board review

(A) In general

The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

(B) DAB hearing procedure

In reviewing a decision on a hearing under this paragraph, the Departmental Appeals Board shall review the case de novo.

(3) Consequences of failure to meet deadlines

(A) Hearing by administrative law judge

In the case of a failure by an administrative law judge to render a decision by the end of the period described in paragraph (1), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

(B) Departmental Appeals Board review

In the case of a failure by the Departmental Appeals Board to render a decision

by the end of the period described in paragraph (2), the party requesting the hearing may seek judicial review, notwithstanding any requirements for a hearing for purposes of the party's right to such judicial review.

(4) Notice

Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the decision; and

(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.

(e) Administrative provisions

(1) Limitation on review of certain regulations

A regulation or instruction that relates to a method for determining the amount of payment under part B and that was initially issued before January 1, 1981, shall not be subject to judicial review.

(2) Outreach

The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this subchapter and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary under section 1395b–2(b) of this title to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

(3) Continuing education requirement for qualified independent contractors and administrative law judges

The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to coverage of items and services under this subchapter or policies of the Secretary with respect to part B of subchapter XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

(4) Reports

(A) Annual report to Congress

The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.

(B) Survey

Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this subchapter who have filed appeals of determinations under this section, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

(f) Review of coverage determinations

(1) National coverage determinations

(A) In general

Review of any national coverage determination shall be subject to the following limitations:

(i) Such a determination shall not be reviewed by any administrative law judge.

(ii) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5 or section 1395hh(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(iii) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the Board determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(iv) The Secretary shall implement a decision of the Departmental Appeals Board within 30 days of receipt of such decision.

(v) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) Definition of national coverage determination

For purposes of this section, the term ''national coverage determination'' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this sub-

chapter, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this subchapter or a determination with respect to the amount of payment made for a particular item or service so covered.

(2) Local coverage determination

(A) In general

Review of any local coverage determination shall be subject to the following limitations:

(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge. The administrative law judge—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the administrative law judge determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(ii) Upon the filing of a complaint by an aggrieved party, a decision of an administrative law judge under clause (i) shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

(iii) The Secretary shall implement a decision of the administrative law judge or the Departmental Appeals Board within 30 days of receipt of such decision.

(iv) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) Definition of local coverage determination

For purposes of this section, the term ''local coverage determination'' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1395y(a)(1)(A) of this title.

(C) Local coverage determinations for clinical diagnostic laboratory tests

For provisions relating to local coverage determinations for clinical diagnostic laboratory tests, see section 1395m–1(g) of this title.

(3) No material issues of fact in dispute

In the case of a determination that may otherwise be subject to review under paragraph (1)(A)(iii) or paragraph (2)(A)(i), where the moving party alleges that—

(A) there are no material issues of fact in dispute, and

(B) the only issue of law is the constitutionality of a provision of this subchapter, or that a regulation, determination, or ruling by the Secretary is invalid,

the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

(4) Pending national coverage determinations

(A) In general

In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an aggrieved person (as described in paragraph (5)) may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request (notwithstanding the receipt by the Secretary of new evidence (if any) during such 90-day period), the Secretary shall take one of the following actions:

(i) Issue a national coverage determination, with or without limitations.

(ii) Issue a national noncoverage determination.

(iii) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

(iv) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in clause (i), (ii), or (iii).

(B) Deemed action by the Secretary

In the case of an action described in subparagraph (A)(iv), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in subparagraph (A)(iii) as of the deadline.

(C) Explanation of determination

When issuing a determination under subparagraph (A), the Secretary shall include an explanation of the basis for the determination. An action taken under subparagraph (A) (other than clause (iv)) is deemed to be a national coverage determination for purposes of review under paragraph (1)(A).

(5) Standing

An action under this subsection seeking review of a national coverage determination or local coverage determination may be initiated only by individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

(6) Publication on the Internet of decisions of hearings of the Secretary

Each decision of a hearing by the Secretary with respect to a national coverage determina-

tion shall be made public, and the Secretary shall publish each decision on the Medicare[4] Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

(7) Annual report on national coverage determinations

(A) In general

Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this subchapter, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make and implement the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making and implementing such determinations.

(B) Publication of reports on the Internet

The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

(8) Construction

Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section insofar as such review is explicitly prohibited or restricted under another provision of law.

(g) Qualifications of reviewers

(1) In general

In reviewing determinations under this section, a qualified independent contractor shall assure that—

(A) each individual conducting a review shall meet the qualifications of paragraph (2);

(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a ''reviewing professional''), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) Independence

(A) In general

Subject to subparagraph (B), each individual conducting a review in a case shall—

(i) not be a related party (as defined in paragraph (5));

(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

(iii) not otherwise have a conflict of interest with such a party.

(B) Exception

Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

(I) the individual is not involved in the provision of items or services in the case under review;

(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term ''participation agreement'' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

(3) Limitations on reviewer compensation

Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

(4) Licensure and expertise

Each reviewing professional shall be—

(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at

[4] So in original. Probably should not be capitalized.

issue and has medical expertise in the field of practice that is appropriate for such items or services.

(5) Related party defined

For purposes of this section, the term ''related party'' means, with respect to a case under this subchapter involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative).

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment) involved in the case are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined under any regulations to have a substantial interest in the case involved.

(h) Prior determination process for certain items and services

(1) Establishment of process

(A) In general

With respect to a medicare administrative contractor that has a contract under section 1395kk–1 of this title that provides for making payments under this subchapter with respect to physicians' services (as defined in section 1395w–4(j)(3) of this title), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

(B) Eligible requester

For purposes of this subsection, each of the following shall be an eligible requester:

(i) A participating physician, but only with respect to physicians' services to be furnished to an individual who is entitled to benefits under this subchapter and who has consented to the physician making the request under this subsection for those physicians' services.

(ii) An individual entitled to benefits under this subchapter, but only with respect to a physicians' service for which the individual receives, from a physician, an advance beneficiary notice under section 1395pp(a) of this title.

(2) Secretarial flexibility

The Secretary shall establish by regulation reasonable limits on the physicians' services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians' service, administrative costs and burdens, and other relevant factors.

(3) Request for prior determination

(A) In general

Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians' service, as to whether the physicians' service is covered under this subchapter consistent with the applicable requirements of section 1395y(a)(1)(A) of this title (relating to medical necessity).

(B) Accompanying documentation

The Secretary may require that the request be accompanied by a description of the physicians' service, supporting documentation relating to the medical necessity for the physicians' service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

(4) Response to request

(A) In general

Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

(i) the physicians' service is so covered;

(ii) the physicians' service is not so covered; or

(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians' service.

(B) Contents of notice for certain determinations

(i) Noncoverage

If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and a description of any applicable rights under subsection (a).

(ii) Insufficient information

If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

(C) Deadline to respond

Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

(D) Informing beneficiary in case of physician request

In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians' service is proposed to be furnished shall be informed of any deter-

mination described in subparagraph (A)(ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians' service and have a claim submitted for the physicians' service.

(5) Binding nature of positive determination

If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

(6) Limitation on further review

(A) In general

Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

(B) Decision not to seek prior determination or negative determination does not impact right to obtain services, seek reimbursement, or appeal rights

Nothing in this subsection shall be construed as affecting the right of an individual who—

(i) decides not to seek a prior determination under this subsection with respect to physicians' services; or

(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such physicians' services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians' service shall not be taken into account in such administrative or judicial review.

(C) No prior determination after receipt of services

Once an individual is provided physicians' services, there shall be no prior determination under this subsection with respect to such physicians' services.

(i) Mediation process for local coverage determinations

(1) Establishment of process

The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare & Medicaid Services.

(2) Responsibility of mediator

Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1395x(d) of this title), and the medical director for a medicare administrative contractor whenever the regional administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.

(Aug. 14, 1935, ch. 531, title XVIII, §1869, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 330; amended Pub. L. 92–603, title II, §299O(a), Oct. 30, 1972, 86 Stat. 1464; Pub. L. 98–369, div. B, title III, §2354(b)(35), July 18, 1984, 98 Stat. 1102; Pub. L. 99–509, title IX, §§9313(a)(1), (b)(1), 9341(a)(1), Oct. 21, 1986, 100 Stat. 2002, 2037; Pub. L. 100–93, §8(e), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4082(a), (b), 4085(i)(18), (19), Dec. 22, 1987, 101 Stat. 1330–128, 1330–133; Pub. L. 103–296, title I, §108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 105–33, title IV, §4611(c), Aug. 5, 1997, 111 Stat. 473; Pub. L. 106–554, §1(a)(6) [title V, §§521(a), 522(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–534, 2763A–543; Pub. L. 108–173, title IX, §§931(d), 932(a), 933(a)(1), (b)–(d)(3), 938(a), 940(a), (b)(1), 940A(a), 948(b)(1), (c), Dec. 8, 2003, 117 Stat. 2399, 2402–2406, 2413, 2416, 2417, 2426; Pub. L. 112–40, title II, §261(a)(3)(A), (F), Oct. 21, 2011, 125 Stat. 423; Pub. L. 113–93, title II, §216(b)(2), Apr. 1, 2014, 128 Stat. 1060.)

Editorial Notes

AMENDMENTS

2014—Subsec. (f)(2)(C). Pub. L. 113–93 added subpar. (C).

2011—Subsec. (a)(1)(C). Pub. L. 112–40, §261(a)(3)(A), substituted ''quality improvement'' for ''utilization and quality control peer review''.

Subsec. (c)(3)(G). Pub. L. 112–40, §261(a)(3)(F), substituted ''quality improvement organizations'' for ''peer review organizations''.

2003—Subsec. (a)(3)(C)(ii). Pub. L. 108–173, §940(a)(1), substituted ''60-day period'' for ''30-day period'' in two places.

Subsec. (a)(4), (5). Pub. L. 108–173, §933(c)(1), added pars. (4) and (5).

Subsec. (b)(1)(A). Pub. L. 108–173, §932(a)(1)(A), inserted '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''.

Subsec. (b)(1)(E)(iii). Pub. L. 108–173, §940(b)(1), added cl. (iii).

Subsec. (b)(1)(F)(ii). Pub. L. 108–173, §932(a)(2), amended heading and text of cl. (ii) generally. Prior to amendment, text read as follows: ''In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.''

Subsec. (b)(2). Pub. L. 108–173, §932(a)(1)(B), added par. (2).

Subsec. (b)(3). Pub. L. 108–173, §933(a)(1), added par. (3).

Subsec. (c)(3)(A). Pub. L. 108–173, §933(d)(1)(A), substituted ''sufficient medical, legal, and other expertise (including knowledge of the program under this subchapter) and sufficient staffing'' for ''sufficient training and expertise in medical science and legal matters''.

Subsec. (c)(3)(B)(i). Pub. L. 108–173, §933(b), inserted ''(including the medical records of the individual involved)'' after ''clinical experience''.

Subsec. (c)(3)(C)(i). Pub. L. 108–173, §940(a)(2), substituted ''60-day period'' for ''30-day period''.

Subsec. (c)(3)(D). Pub. L. 108–173, §933(d)(2)(A), amended heading and text of subpar. (D) generally, substituting provisions directing that subsec. (g) requirements be met for provisions prohibiting a physician or health care professional from reviewing a determination where such physician or health care professional

had been directly responsible for furnishing services or had had a significant financial interest in the institution, organization, or agency which provided the services.

Subsec. (c)(3)(E). Pub. L. 108–173, §933(c)(2), inserted ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing,'' and ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision,''.

Subsec. (c)(3)(I)(ii)(III). Pub. L. 108–173, §948(b)(1)(A), substituted ''determination'' for ''policy''.

Subsec. (c)(3)(I)(ii)(IV). Pub. L. 108–173, §948(b)(1)(B), substituted ''coverage determinations'' for ''medical review policies''.

Subsec. (c)(3)(J)(i). Pub. L. 108–173, §933(c)(4), substituted ''submit'' for ''prepare'' and struck out ''with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues involved in the decision and relevant policies'' after ''decision of the contractor''.

Subsec. (c)(3)(K). Pub. L. 108–173, §933(d)(1)(B), added subpar. (K).

Subsec. (c)(4). Pub. L. 108–173, §933(d)(3), substituted ''a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection'' for ''not fewer than 12 qualified independent contractors under this subsection''.

Subsec. (d). Pub. L. 108–173, §933(c)(3)(A), inserted ''; notice'' after ''Secretary'' in heading.

Subsec. (d)(4). Pub. L. 108–173, §933(c)(3)(B), added par. (4).

Subsec. (f)(2)(A)(i). Pub. L. 108–173, §931(d), struck out ''of the Social Security Administration'' after ''an administrative law judge'' in introductory provisions.

Subsec. (f)(4)(A)(iv). Pub. L. 108–173, §948(c)(1), substituted ''clause (i), (ii), or (iii)'' for ''subclause (I), (II), or (III)''.

Subsec. (f)(4)(B). Pub. L. 108–173, §948(c)(2), substituted ''subparagraph (A)(iv)'' for ''clause (i)(IV)'' and ''subparagraph (A)(iii)'' for ''clause (i)(III)''.

Subsec. (f)(4)(C). Pub. L. 108–173, §948(c)(3), substituted ''subparagraph (A)'' for ''clause (i)'' in two places, ''clause (iv)'' for ''subclause (IV)'', and ''paragraph (1)(A)'' for ''subparagraph (A)''.

Subsec. (g). Pub. L. 108–173, §933(d)(2)(B), added subsec. (g).

Subsec. (h). Pub. L. 108–173, §938(a), added subsec. (h).

Subsec. (i). Pub. L. 108–173, §940A(a), added subsec. (i).

2000—Pub. L. 106–554, §1(a)(6) [title V, §521(a)], amended section generally, completely revising and expanding provisions relating to determinations with respect to benefits under part A or part B of this subchapter, changing the structure of the section from two subsecs. lettered (a) and (b) to five subsecs. lettered (a) to (e).

Subsec. (f). Pub. L. 106–554, §1(a)(6) [title V, §522(a)], added subsec. (f).

1997—Subsec. (b)(2)(B). Pub. L. 105–33 inserted ''(or $100 in the case of home health services)'' after ''$500''.

1994—Subsec. (b)(1). Pub. L. 103–296 inserted '', except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively'' after ''section 405(g) of this title'' in closing provisions.

1987—Subsec. (a). Pub. L. 100–203, §4085(i)(18), inserted ''or a claim for benefits with respect to home health services under part B of this subchapter'' before ''shall''.

Subsec. (b)(2). Pub. L. 100–203, §4085(i)(19), inserted ''and (1)(D)'' after ''paragraph (1)(C)'' in two places.

Subsec. (b)(3)(B). Pub. L. 100–203, §4082(a), substituted ''section 553'' for ''chapter 5''.

Subsec. (b)(5). Pub. L. 100–203, §4082(b), added par. (5).

Subsec. (c). Pub. L. 100–93 struck out subsec. (c) which read as follows: ''Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.''

1986—Subsec. (a). Pub. L. 99–509, §9341(a)(1)(A), inserted ''or part B'' after ''amount of benefits under part A''.

Pub. L. 99–509, §9313(b)(1)(A), inserted ''and any other determination with respect to a claim for benefits under part A of this subchapter'' before ''shall''.

Subsec. (b)(1). Pub. L. 99–509, §9313(a)(1), in concluding provisions, inserted at end ''Sections 406(a), 1302, and 1395hh of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1395pp(a)(2) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.''

Subsec. (b)(1)(C). Pub. L. 99–509, §9341(a)(1)(B), inserted ''or part B''.

Subsec. (b)(1)(D). Pub. L. 99–509, §9313(b)(1)(B), added subpar. (D).

Subsec. (b)(2). Pub. L. 99–509, §9341(a)(1)(C), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.''

Subsec. (b)(3), (4). Pub. L. 99–509, §9341(a)(1)(D), added pars. (3) and (4).

1984—Subsec. (b)(1)(B). Pub. L. 98–369 struck out the comma before ''or section 1395i–2'' and struck out '', or section 1819'' after ''section 1395i–2 of this title''.

1972—Subsec. (b). Pub. L. 92–603 redesignated existing provisions as par. (1), generally amended conditions under which a dissatisfied individual shall be entitled to a hearing by Secretary and to judicial review of final decision of Secretary after such hearing, and added par. (2).

Statutory Notes and Related Subsidiaries

Change of Name

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Effective Date of 2011 Amendment

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

Effective Date of 2003 Amendment

Amendment by section 932(a) of Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section

932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

Pub. L. 108–173, title IX, §933(a)(2), Dec. 8, 2003, 117 Stat. 2402, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 2004.''

Pub. L. 108–173, title IX, §933(d)(4), Dec. 8, 2003, 117 Stat. 2406, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554] (114 Stat. 2763A–534).''

Pub. L. 108–173, title IX, §938(b), Dec. 8, 2003, 117 Stat. 2415, provided that:

''(1) EFFECTIVE DATE.—The Secretary [of Health and Human Services] shall establish the prior determination process under the amendment made by subsection (a) [amending this section] in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003].

''(2) SUNSET.—Such prior determination process shall not apply to requests filed after the end of the 5-year period beginning on the first date on which requests for determinations under such process are accepted.

''(3) TRANSITION.—During the period in which the amendment made by subsection (a) [amending this section] has become effective but contracts are not provided under section 1874A of the Social Security Act [42 U.S.C. 1395kk–1] with medicare administrative contractors, any reference in section 1869(g) [probably should be 1869(h)] of such Act [42 U.S.C. 1395ff(h)] (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act [42 U.S.C. 1395h, 1395u].

''(4) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) [amending this section] shall not be considered to be a change in law or regulation.''

Amendment by section 948(b)(1), (c) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554], see section 948(e) of Pub. L. 108–173, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section §1(a)(6) [title V, §521(a)] of Pub. L. 106–554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106–554, set out as a note under section 1320c–3 of this title.

Amendment by section 1(a)(6) [title V, §522(a)] of Pub. L. 106–554 applicable with respect to a review of any national or local coverage determination filed, a request to make such a determination made, and a national coverage determination made, on or after Oct. 1, 2001, see section 1(a)(6) [title V, §522(d)] of Pub. L. 106–554, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4082(e)(1), (2), Dec. 22, 1987, 101 Stat. 1330–128, provided that:

''(1) The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

''(2) The amendment made by subsection (b) [amending this section] shall apply to requests for hearings filed after the end of the 60-day period beginning on the date of the enactment of this Act.''

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9313(b)(2), Oct. 21, 1986, 100 Stat. 2003, provided that: ''The amendments made by this subsection [amending this section] take effect on the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–509, title IX, §9341(b), Oct. 21, 1986, 100 Stat. 2038, provided that: ''The amendments made by subsection (a) [amending this section and sections 1395u and 1395pp of this title] shall apply to items and services furnished on or after January 1, 1987.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §299O(b), Oct. 30, 1972, 86 Stat. 1465, provided that:

''(1) The provisions of subparagraphs (A) and (B) of section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)(A), (B)], as amended by subsection (a) of this section, shall be effective on the date of enactment of this Act [Oct. 30, 1972].

''(2) The provisions of paragraph (2) and subparagraph (C) of paragraph (1) of section 1869(b) of the Social Security Act [42 U.S.C. 1395ff(b)(2), (b)(1)(C)], as amended by subsection (a) of this section, shall be effective with respect to any claims under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.], filed—

''(A) in or after the month in which this Act is enacted [Oct. 1972], or

''(B) before the month in which this Act is enacted [Oct. 1972], but only if a civil action with respect to a final decision of the Secretary of Health, Education, and Welfare on such claim has not been commenced under such section 1869(b) [42 U.S.C. 1395ff(b)] before such month.''

TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS

Pub. L. 108–173, title IX, §931(a)–(c), Dec. 8, 2003, 117 Stat. 2396–2398, provided that:

''(a) TRANSITION PLAN.—

''(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary [of Health and Human Services] shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (and related provisions in title XI of such Act [42 U.S.C. 1301 et seq.]) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

''(2) CONTENTS.—The plan shall include information on the following:

''(A) WORKLOAD.—The number of such administrative law judges and support staff required now and

in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

''(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

''(C) TRANSITION TIMETABLE.—A timetable for the transition.

''(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

''(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

''(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

''(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

''(i) filing appeals with administrative law judges electronically; and

''(ii) conducting hearings using tele- or video-conference technologies.

''(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

''(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

''(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

''(K) PERFORMANCE STANDARDS.—The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code[,] relating to impartiality.

''(L) SHARED RESOURCES.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

''(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

''(4) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

''(b) TRANSFER OF ADJUDICATION AUTHORITY.—

''(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

''(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

''(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

''(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

''(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

''(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

''(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

''(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

''(2) improve education and training opportunities for administrative law judges (and their staffs); and

''(3) increase the staff of the Departmental Appeals Board.''

TRANSITION

Pub. L. 108–173, title IX, § 933(d)(5), Dec. 8, 2003, 117 Stat. 2406, provided that: ''In applying section 1869(g) of the Social Security Act [42 U.S.C. 1395ff(g)] (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).''

PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS

Pub. L. 108–173, title IX, § 937, Dec. 8, 2003, 117 Stat. 2412, provided that:

''(a) CLAIMS.—The Secretary [of Health and Human Services] shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act [42 U.S.C. 1395zz(g)], as inserted by section 301(a)(1) [probably should be 921(f)(1)]) and representatives of providers of services

and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act [42 U.S.C. 1395 et seq.], a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

''(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall first develop the process under subsection (a).''

STUDY OF AGGREGATION RULE FOR CLAIMS FOR SIMILAR PHYSICIANS' SERVICES

Pub. L. 101–508, title IV, § 4113, Nov. 5, 1990, 104 Stat. 1388–64, directed Secretary of Health and Human Services to carry out a study of the effects of permitting the aggregation of claims that involve common issues of law and fact furnished in the same carrier area to two or more individuals by two or more physicians within the same 12-month period for purposes of appeals provided for under subsec. (b)(2) of this section, and to report on the results of such study and any recommendations to Congress by Dec. 31, 1992.

MEDICARE HEARINGS AND APPEALS

Pub. L. 100–203, title IV, § 4037, Dec. 22, 1987, 101 Stat. 1330–80, provided that:

''(a) MAINTAINING CURRENT SYSTEM FOR HEARINGS AND APPEALS.—Any hearing conducted under section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)] prior to the earliest of the date on which the Secretary of Health and Human Services submits the report required to be submitted by the Secretary under subsection (b)(1) or September 1 shall be conducted by Administrative Law Judges of the Office of Hearings and Appeals of the Social Security Administration in the same manner as are hearings conducted under section 205(b)(1) of such Act [42 U.S.C. 405(b)(1)].

''(b) STUDY AND REPORT ON USE OF TELEPHONE HEARINGS.—

''(1) The Secretary of Health and Human Services and the Comptroller General of the United States shall each conduct a study on holding hearings under section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)] by telephone and shall each report the results of the study not later than 6 months after the date of enactment of this Act [Dec. 22, 1987].

''(2) The studies under paragraph (1) shall focus on whether telephone hearings allow for a full and fair evidentiary hearing, in general, or with respect to any particular category of claims and shall examine the possible improvements to the hearing process (such as cost-effectiveness, convenience to the claimant, and reduction in time under the process) resulting from the use of such hearings as compared to the adoption of other changes to the process (such as expansions in staff and resources).''

§ 1395gg. Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals

(a) Payments to providers of services or other person regarded as payment to individuals

Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Incorrect payments on behalf of individuals; payment adjustment

Where—

(1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1395f(e) of this title to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]) the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(c) Exception to subsection (b) payment adjustment

There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of subchapter II or subchapter XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent

with the purposes of this subchapter) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this subchapter by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the fifth year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(d) Liability of certifying or disbursing officer for failure to recoup

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) Settlement of claims for benefits under this subchapter on behalf of deceased individuals

If an individual, who received services for which payment may be made to such individual under this subchapter, dies, and payment for such services was made (other than under this subchapter), and the individual died before any payment due him under this subchapter with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this subchapter is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) Settlement of claims for section 1395k benefits on behalf of deceased individuals

If an individual who received medical and other health services for which payment may be made under section 1395k(a)(1) of this title dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

(g) Refund of premiums for deceased individuals

If an individual, who is enrolled under section 1395i–2(c) of this title or under section 1395p of this title, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

(h) Appeals by providers of services or suppliers

Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this subchapter relating to services rendered under this subchapter to an individual who subsequently dies if there is no other party available to appeal such determination.

(Aug. 14, 1935, ch. 531, title XVIII, §1870, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 331; amended Pub. L. 90–248, title I, §154(b), (c), Jan. 2, 1968, 81 Stat. 862; Pub. L. 92–603, title II, §§261(a), 266, 281(a), (b), Oct. 30, 1972, 86 Stat. 1448, 1450, 1454, 1455; Pub. L. 93–445, title III, §309, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 96–499, title IX, §954(a), Dec. 5, 1980, 94 Stat. 2647; Pub. L. 97–248, title I, §128(d)(1), Sept. 3, 1982, 96 Stat. 367; Pub. L. 100–203, title IV, §§4039(h)(7), 4096(a)(2), Dec, 22, 1987, 101 Stat. 1330–139, as amended Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776; Pub. L. 100–360, title IV, §411(j)(4)(B), July 1, 1988, 102 Stat. 791; Pub. L. 108–173, title IX, §939(a), Dec. 8, 2003, 117 Stat. 2416; Pub. L. 112–240, title VI, §638(a), Jan. 2, 2013, 126 Stat. 2357.)

Editorial Notes

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (b), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

AMENDMENTS

2013—Subsecs. (b), (c). Pub. L. 112–240 substituted ''fifth year'' for ''third year'' and ''five-year'' for ''three-year'' in last sentence.

2003—Subsec. (h). Pub. L. 108–173 added subsec. (h).

1988—Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(7), see 1987 Amendment note below.

Subsec. (f)(1), (2). Pub. L. 100–360, §411(j)(4)(B), substituted ''of assignment specified in'' for ''specified in subclauses (I) and (II) of''.

1987—Pub. L. 100–203, §4039(h)(7), as added by Pub. L. 100–360, §411(e)(3), amended section catchline generally.

Subsec. (f)(1), (2). Pub. L. 100–203, §4096(a)(2), substituted ''to the terms specified in subclauses (I) and (II) of section 1395u(b)(3)(B)(ii) of this title with respect to the services'' for ''that the reasonable charge is the full charge for the services''.

1982—Subsec. (c). Pub. L. 97–248 substituted ''section 1395y(a)'' for ''section 1395y''.

1980—Subsec. (f). Pub. L. 96–499 amended subsec. (f) generally, inserting provision for payments to providers of medical and other health services where the person or persons furnishing the services did not agree that the reasonable charge was the full charge for such services.

1974—Subsec. (b). Pub. L. 93–445 substituted ''Railroad Retirement Act of 1974'' for ''Railroad Retirement Act of 1937'', wherever appearing.

1972—Subsec. (b). Pub. L. 92–603, §281(a), required that provider of services or other person be without fault with respect to payment of excess over correct amount as prerequisite to adjustment or recovery of incorrect payments.

Subsec. (c). Pub. L. 92–603, §§261(a), 281(b), substituted ''or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if'' for ''and where'', inserted reference to subchapter XVIII of this chapter, and inserted provisions covering the adjustment or recovery of incorrect payments against individuals who are without fault.

Subsec. (g). Pub. L. 92–603, §266, added subsec. (g).

1968—Pub. L. 90–248, §154(b), provided for settlement of claims for benefits on behalf of deceased individuals in section catchline.

Subsecs. (e), (f). Pub. L. 90–248, §154(c), added subsecs. (e) and (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 112–240, title VI, §638(b), Jan. 2, 2013, 126 Stat. 2357, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Jan. 2, 2013].''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §939(b), Dec. 8, 2003, 117 Stat. 2416, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003] and shall apply to items and services furnished on or after such date.''

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4096(a)(2) of Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §954(b), Dec. 5, 1980, 94 Stat. 2647, provided that: ''The amendment made by this section [amending this section] shall apply only to claims filed on or after January 1, 1981.''

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, § 261(b), Oct. 30, 1972, 86 Stat. 1448, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to waiver actions considered after the date of the enactment of this Act [Oct. 30, 1972].''

Pub. L. 92–603, title II, § 281(g), Oct. 30, 1972, 86 Stat. 1456, provided that: ''The provisions of subsection (a)(1) [amending this section] shall apply with respect to notices of payment sent to individuals after the date of enactment of this Act [Oct. 30, 1972]. The provisions of subsections (a)(2), (b), (c), and (d) [amending this section and sections 1395u and 1395cc of this title] shall apply in the case of notices sent to individuals after 1968. The provisions of subsections (e) and (f) [amending sections 1395f and 1395n of this title] shall apply in the case of services furnished (or deemed to have been furnished) after 1970.''

WAIVER OF LIABILITY LIMITING RECOUPMENT IN CERTAIN CASES

Pub. L. 101–239, title VI, § 6109, Dec. 19, 1989, 103 Stat. 2213, provided that: ''In the case where more than the correct amount may have been paid to a physician or individual under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to services furnished during the period beginning on July 1, 1985, and ending on March 31, 1986, as a result of a carrier's establishing statewide fees for certain procedure codes while the carrier was in the process of implementing the national common procedure coding system of the Health Care Financing Administration, the provisions of section 1870(c) of the Social Security Act [42 U.S.C. 1395gg(c)] shall apply, without the need for affirmative action by such a physician or individual, so as to prevent any recoupment, or other decrease in subsequent payments, to the physician or individual. The previous sentence shall apply to claims for items and services which were reopened by carriers on or after July 31, 1987.''

§ 1395hh. Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term ''regulations'' means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) Publication of certain rules; public inspection; changes in data collection and retrieval

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

(e)[1] Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(2)(A) If—

(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1395zz(g) of this title) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this subchapter or the provisions of subchapter XI insofar as they relate to this subchapter (including interest under a repayment plan under section 1395ddd of this title or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.

(f) Report on areas of inconsistency or conflict

(1) Not later than 2 years after December 8, 2003, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this subchapter and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall collect—

(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

(Aug. 14, 1935, ch. 531, title XVIII, §1871, as added Pub. L. 89–97, title I, §102(a) July 30, 1965, 79 Stat. 331; amended Pub. L. 99–509, title IX, §9321(e)(1), Oct. 21, 1986, 100 Stat. 2017; Pub. L. 100–203, title IV, §4035(b), (c), Dec. 22, 1987, 101 Stat. 1330–78; Pub. L. 108–173, title IX, §§902(a)(1), (b)(1), 903(a)(1), (b)(1), (c)(1), 904(b), Dec. 8, 2003, 117 Stat. 2375–2377.)

Editorial Notes

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108–173, §902(a)(1), added par. (3).

Subsec. (a)(4). Pub. L. 108–173, §902(b)(1), added par. (4).

[1] So in original. No subsec. (d) has been enacted.

Subsec. (e). Pub. L. 108–173, § 903(a)(1), added subsec. (e).

Subsec. (e)(1)(B), (C). Pub. L. 108–173, § 903(b)(1), added subpars. (B) and (C).

Subsec. (e)(2). Pub. L. 108–173, § 903(c)(1), added par. (2).

Subsec. (f). Pub. L. 108–173, § 904(b), added subsec. (f).

1987—Subsec. (a). Pub. L. 100–203, § 4035(b), designated existing provisions as par. (1) and added par. (2).

Subsec. (c). Pub. L. 100–203, § 4035(c), added subsec. (c).

1986—Pub. L. 99–509 designated existing provisions as subsec. (a) and added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 902(a)(2), Dec. 8, 2003, 117 Stat. 2375, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003]. The Secretary [of Health and Human Services] shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.''

Pub. L. 108–173, title IX, § 902(b)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to final regulations published on or after the date of the enactment of this Act [Dec. 8, 2003].''

Pub. L. 108–173, title IX, § 903(a)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to substantive changes issued on or after the date of the enactment of this Act [Dec. 8, 2003].''

Pub. L. 108–173, title IX, § 903(b)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to compliance actions undertaken on or after the date of the enactment of this Act [Dec. 8, 2003].''

Pub. L. 108–173, title IX, § 903(c)(2), Dec. 8, 2003, 117 Stat. 2377, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003] and shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.''

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 effective Dec. 22, 1987, and applicable to budgets for fiscal years beginning with fiscal year 1989, see section 4035(a)(3) of Pub. L. 100–203, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9321(e)(3)(A), Oct. 21, 1986, 100 Stat. 2018, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act [Oct. 21, 1986].''

REGULATIONS

Pub. L. 101–508, title IV, § 4207(j), formerly § 4027(j), Nov. 5, 1990, 104 Stat. 1388–124, as renumbered and amended by Pub. L. 103–432, title I, § 160(d)(4), (12), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle [subtitle A (§§ 4000–4361) of title IV of Pub. L. 101–508, see Tables for classification] and the amendments made by this subtitle.''

Section 4039(g) of title IV of Pub. L. 100–203 provided that: ''The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle and the amendments made by this subtitle [subtitle A (§§ 4001–4097) of title IV of Pub. L. 100–203, see Tables for classification].''

REQUIRING THE POSTING AND PERIODIC UPDATE OF OPIOID PRESCRIBING GUIDANCE FOR MEDICARE BENEFICIARIES

Pub. L. 115–271, title VI, § 6095, Oct. 24, 2018, 132 Stat. 4003, provided that:

''(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall post on the public website of the Centers for Medicare & Medicaid Services all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids and applicable to opioid prescriptions for individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) or enrolled under part B of such title of such Act (42 U.S.C. 1395j et seq.).

''(b) UPDATE OF GUIDANCE.—

''(1) PERIODIC UPDATE.—The Secretary shall, in consultation with the entities specified in paragraph (2), periodically (as determined appropriate by the Secretary) update guidance described in subsection (a) and revise the posting of such guidance on the website described in such subsection.

''(2) CONSULTATION.—The entities specified in this paragraph are the following:

''(A) Medical professional organizations.

''(B) Providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x)).

''(C) Health care consumers or groups representing such consumers.

''(D) Other entities determined appropriate by the Secretary.''

GAO STUDY ON ADVISORY OPINION AUTHORITY

Pub. L. 108–173, title IX, § 904(a), Dec. 8, 2003, 117 Stat. 2377, provided that:

''(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary [of Health and Human Services] authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

''(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003].''

§ 1395ii. Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (*l*) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(Aug. 14, 1935, ch. 531, title XVIII, § 1872, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 332; amended Pub. L. 92–603, title II, § 242(a), Oct. 30, 1972, 86 Stat. 1419; Pub. L. 98–369, div. B, title III, § 2354(b)(36), July 18, 1984, 98

Stat. 1102; Pub. L. 103–296, title I, § 108(c)(4), Aug. 15, 1994, 108 Stat. 1485.)

Editorial Notes

AMENDMENTS

1994—Pub. L. 103–296 inserted before period at end '', except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively''.

1984—Pub. L. 98–369 struck out the comma after ''406'' and struck out reference to subsec. (f) of section 405 of this title.

1972—Pub. L. 92–603 struck out reference to provisions of section 408 of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 not applicable to any acts, statements, or representations made or committed prior to Oct. 30, 1972, see section 242(d) of Pub. L. 92–603, set out as an Effective Date note under section 1320a–7b of this title.

§ 1395jj. Designation of organization or publication by name

Designation in this subchapter, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

(Aug. 14, 1935, ch. 531, title XVIII, § 1873, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 332.)

§ 1395kk. Administration of insurance programs

(a) Functions of Secretary; performance directly or by contract

Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) Contracts to secure special data, actuarial information, etc.

The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this subchapter.

(c) Oaths and affirmations

In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this subchapter, the Secretary may administer oaths and affirmations.

(d) Inclusion of Medicare provider and supplier payments in Federal Payment Levy Program

(1) In general

The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

(A) at least 50 percent of all payments under parts A and B are processed through such program beginning within 1 year after July 15, 2008; [1]

(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after July 15, 2008; and

(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

(2) Assistance

The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Payment Levy Program by the deadlines specified in that subsection.

(e) Availability of data

(1) In general

Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) Qualified entities

For purposes of this subsection, the term ''qualified entity'' means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) Data described

The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the

[1] See References in Text note below.

Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under subchapters[2] XIX or XXI.

(4) Requirements

(A) Fee

Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited, for periods prior to July 1, 2016, into the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account.

(B) Specification of uses and methodologies

A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1395aaa(a) of this title and measures developed pursuant to section 299b–31 of this title; or

(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iii) include data made available under this subsection with claims data from sources other than claims data under this subchapter in the evaluation of performance of providers of services and suppliers;

(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) Reports

Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

(iv) except as described in clause (ii), be made available to the public.

(D) Approval and limitation of uses

The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

(f) Requirement for the Secretary to establish policies and claims edits relating to incarcerated individuals, individuals not lawfully present, and deceased individuals

The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this subchapter for items and services furnished to an individual who is one of the following:

(1) An individual who is incarcerated.

(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this subchapter.

(3) A deceased individual.

(g) Requirement for enrollment data reporting

(1) In general

Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

(A) by Congressional district and State; and

[2] So in original. Probably should be ''subchapter''.

(B) in a manner that provides for such data based on—

(i) fee-for-service enrollment (as defined in paragraph (2));

(ii) enrollment under part C (including separate for aggregate enrollment in MA–PD plans and aggregate enrollment in MA plans that are not MA–PD plans); and

(iii) enrollment under part D.

(2) Fee-for-service enrollment defined

For purpose of paragraph (1)(B)(i), the term ''fee-for-service enrollment'' means aggregate enrollment (including receipt of benefits other than through enrollment) under—

(A) part A only;

(B) part B only; and

(C) both part A and part B.

(Aug. 14, 1935, ch. 531, title XVIII, § 1874, as added and amended Pub. L. 89–97, title I, §§ 102(a), 111(a), July 30, 1965, 79 Stat. 332, 340; Pub. L. 92–603, title II, § 289, Oct. 30, 1972, 86 Stat. 1457; Pub. L. 93–445, title III, § 310, Oct. 16, 1974, 88 Stat. 1359; Pub. L. 110–275, title I, § 189(a), July 15, 2008, 122 Stat. 2590; Pub. L. 111–148, title X, § 10332(a), Mar. 23, 2010, 124 Stat. 968; Pub. L. 114–10, title I, § 105(c), (d), title V, § 502(a), Apr. 16, 2015, 129 Stat. 137, 165; Pub. L. 114–255, div. C, title XVII, § 17002, Dec. 13, 2016, 130 Stat. 1330.)

Editorial Notes

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (a), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, § 101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§ 231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (d)(1), is classified generally to Title 26, Internal Revenue Code.

July 15, 2008, referred to in subsec. (d)(1)(A) and (B), was in the original ''the date of the enactment of this section'' and ''such date'', which were translated as meaning the date of enactment of Pub. L. 110–275, which enacted subsec. (d), to reflect the probable intent of Congress.

AMENDMENTS

2016—Subsec. (g). Pub. L. 114–255 added subsec. (g).

2015—Subsec. (e). Pub. L. 114–10, § 105(c)(1), struck out ''Medicare'' before ''data'' in heading.

Subsec. (e)(3). Pub. L. 114–10, § 105(c)(2), inserted ''Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity.'' before ''The Secretary'' and ''or under subchapters XIX or XXI'' before period at end.

Subsec. (e)(4)(A). Pub. L. 114–10, § 105(d), inserted '', for periods prior to July 1, 2016,'' after ''deposited'' and '', and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account'' before period at end.

Subsec. (f). Pub. L. 114–10, § 502(a), added subsec. (f).

2010—Subsec. (e). Pub. L. 111–148 added subsec. (e).

2008—Subsec. (d). Pub. L. 110–275 added subsec. (d).

1974—Subsec. (a). Pub. L. 93–445 substituted ''Railroad Retirement Act of 1974'' for ''Railroad Retirement Act of 1937''.

1972—Subsec. (c). Pub. L. 92–603 added subsec. (c).

1965—Subsec. (a). Pub. L. 89–97 inserted reference to Railroad Retirement Act of 1937 in first sentence.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title X, § 10332(b), Mar. 23, 2010, 124 Stat. 970, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2012.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 effective July 15, 2008, see section 189(c) of Pub. L. 110–275, set out as a note under section 3716 of Title 31, Money and Finance.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by Pub. L. 89–97 applicable to calendar year 1966 or to any subsequent calendar year but only if by October 1 immediately preceding such calendar year the Railroad Retirement Tax Act provides for a maximum amount of monthly compensation taxable under such Act during all months of such calendar year equal to one-twelfth of maximum wages which Federal Insurance Contributions Act provides may be counted for such calendar year, see Pub. L. 89–97, title I, § 111(e), July 30, 1965, 79 Stat. 343.

REPORT

Pub. L. 114–10, title V, § 502(b), Apr. 16, 2015, 129 Stat. 165, provided that: ''Not later than 18 months after the date of the enactment of this section [Apr. 16, 2015], and periodically thereafter as determined necessary by the Office of Inspector General of the Department of Health and Human Services, such Office shall submit to Congress a report on the activities described in subsection (f) of section 1874 of the Social Security Act (42 U.S.C. 1395kk), as added by subsection (a), that have been conducted since such date of enactment.''

§ 1395kk–1. Contracts with medicare administrative contractors

(a) Authority

(1) Authority to enter into contracts

The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) Eligibility of entities

An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

(A) the entity has demonstrated capability to carry out such function;

(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(C) the entity has sufficient assets to financially support the performance of such function; and

(D) the entity meets such other requirements as the Secretary may impose.

(3) Medicare administrative contractor defined

For purposes of this subchapter and subchapter XI—

(A) In general

The term ''medicare administrative contractor'' means an agency, organization, or other person with a contract under this section.

(B) Appropriate medicare administrative contractor

With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the ''appropriate'' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

(4) Functions described

The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1395ff(f)(2)(B) of this title), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

(A) Determination of payment amounts

Determining (subject to the provisions of section 1395*oo* of this title and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this subchapter to be made to providers of services, suppliers and individuals.

(B) Making payments

Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

(C) Beneficiary education and assistance

Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

(D) Provider consultative services

Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this subchapter and otherwise to qualify as providers of services or suppliers.

(E) Communication with providers

Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(F) Provider education and technical assistance

Performing the functions relating to provider education, training, and technical assistance.

(G) Improper payment outreach and education program

Having in place an improper payment outreach and education program described in subsection (h).

(H) Additional functions

Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1395ddd of this title, as are necessary to carry out the purposes of this subchapter.

(5) Relationship to MIP contracts

(A) Nonduplication of duties

In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1395ddd of this title. The previous sentence shall not apply with respect to the activity described in section 1395ddd(b)(5) of this title (relating to prior authorization of certain items of durable medical equipment under section 1395m(a)(15) of this title).

(B) Construction

An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1395ddd of this title.

(6) Application of Federal Acquisition Regulation

Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

(b) Contracting requirements

(1) Use of competitive procedures

(A) In general

Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

(B) Renewal of contracts

The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 6101 of title 41 or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of

competitive procedures under such a contract not less frequently than once every 10 years.

(C) Transfer of functions

The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

(D) Incentives for quality

(i) In general

Subject to clauses (ii) and (iii), the Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

(ii) Improper payment rate reduction incentives

The Secretary shall provide incentives for medicare administrative contractors to reduce the improper payment error rates in their jurisdictions.

(iii) Incentives

The incentives provided for under clause (ii)—

(I) may include a sliding scale of award fee payments and additional incentives to medicare administrative contractors that either reduce the improper payment rates in their jurisdictions to certain thresholds, as determined by the Secretary, or accomplish tasks, as determined by the Secretary, that further improve payment accuracy; and

(II) may include substantial reductions in award fee payments under cost-plus-award-fee contracts, for medicare administrative contractors that reach an upper end improper payment rate threshold or other threshold as determined by the Secretary, or fail to accomplish tasks, as determined by the Secretary, that further improve payment accuracy.

(2) Compliance with requirements

No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

(3) Performance requirements

(A) Development of specific performance requirements

(i) In general

The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this subchapter to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.

(ii) Consultation

In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this subchapter, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

(iii) Publication of standards

The Secretary shall make such performance requirements and measurement standards available to the public.

(iv) Contractor performance transparency

To the extent possible without compromising the process for entering into and renewing contracts with medicare administrative contractors under this section, the Secretary shall make available to the public the performance of each medicare administrative contractor with respect to such performance requirements and measurement standards.

(B) Considerations

The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

(C) Inclusion in contracts

All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

(ii) shall be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(4) Information requirements

The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this subchapter; and

(B) to maintain such records and afford such access thereto as the Secretary finds

necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this subchapter.

(5) Surety bond

A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(c) Terms and conditions

(1) In general

A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

(2) Prohibition on mandates for certain data collection

The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this subchapter with data used in the administration of this subchapter for purposes of identifying situations in which the provisions of section 1395y(b) of this title may apply.

(d) Limitation on liability of medicare administrative contractors and certain officers

(1) Certifying officer

No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

(2) Disbursing officer

No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

(3) Liability of medicare administrative contractor

(A) In general

No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

(B) Relationship to False Claims Act

Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31.

(4) Indemnification by Secretary

(A) In general

Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this subchapter, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

(B) Conditions

The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(C) Scope of indemnification

Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

(D) Written approval for settlements or compromises

A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

(E) Construction

Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.

(e) Requirements for information security

(1) Development of information security program

A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this subchapter. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b)[1] of title 44 (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

(2) Independent audits

(A) Performance of annual evaluations

Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this subchapter. The evaluation shall—

(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44) relating to such functions under this subchapter and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40.

(B) Deadline for initial evaluation

(i) New contractors

In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1395h or 1395u of this title, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

(ii) Other contractors

In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) Reports on evaluations

(i) To the Department of Health and Human Services

The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

(ii) To Congress

The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

(iii) Agency reporting

The Secretary shall address the results of such evaluations in reports required under section 3544(c)[1] of title 44.

(f) Incentives to improve contractor performance in provider education and outreach

The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.

(g) Communications with beneficiaries, providers of services and suppliers

(1) Communication strategy

The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this subchapter.

(2) Response to written inquiries

Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this subchapter within 45 business days of the date of receipt of such inquiries.

(3) Response to toll-free lines

The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a

[1] See References in Text note below.

toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this subchapter.

(4) Monitoring of contractor responses

(A) In general

Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

(B) Development of standards

(i) In general

The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(ii) Evaluation

In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(C) Direct monitoring

Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(5) Authorization of appropriations

There are authorized to be appropriated such sums as are necessary to carry out this subsection.

(h) Improper payment outreach and education program

(1) In general

In order to reduce improper payments under this subchapter, each medicare administrative contractor shall establish and have in place an improper payment outreach and education program under which the contractor, through outreach, education, training, and technical assistance or other activities, shall provide providers of services and suppliers located in the region covered by the contract under this section with the information described in paragraph (2). The activities described in the preceding sentence shall be conducted on a regular basis.

(2) Information to be provided through activities

The information to be provided under such payment outreach and education program shall include information the Secretary determines to be appropriate, which may include the following information:

(A) A list of the providers' or suppliers' most frequent and expensive payment errors over the last quarter.

(B) Specific instructions regarding how to correct or avoid such errors in the future.

(C) A notice of new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1395ddd(h) of this title.

(D) Specific instructions to prevent future issues related to such new audits.

(E) Other information determined appropriate by the Secretary.

(3) Priority

A medicare administrative contractor shall give priority to activities under such program that will reduce improper payments that are one or more of the following:

(A) Are for items and services that have the highest rate of improper payment.

(B) Are for items and service[2] that have the greatest total dollar amount of improper payments.

(C) Are due to clear misapplication or misinterpretation of Medicare policies.

(D) Are clearly due to common and inadvertent clerical or administrative errors.

(E) Are due to other types of errors that the Secretary determines could be prevented through activities under the program.

(4) Information on improper payments from recovery audit contractors

(A) In general

In order to assist medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each contractor with a complete list of the types of improper payments identified by recovery audit contractors under section 1395ddd(h) of this title with respect to providers of services and suppliers located in the region covered by the contract under this section. Such information shall be provided on a time frame the Secretary determines appropriate which may be on a quarterly basis.

(B) Information

The information described in subparagraph (A) shall include information such as the following:

(i) Providers of services and suppliers that have the highest rate of improper payments.

(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

(iii) Items and services furnished in the region that have the highest rates of improper payments.

[2] So in original. Probably should be ''services''.

(iv) Items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.

(v) Other information the Secretary determines would assist the contractor in carrying out the program.

(5) Communications

Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).

(Aug. 14, 1935, ch. 531, title XVIII, § 1874A, as added and amended Pub. L. 108–173, title IX, §§ 911(a)(1), 912(a), 921(b)(1), (c)(1), 934(a), 940A(b), Dec. 8, 2003, 117 Stat. 2378, 2387–2389, 2406, 2417; Pub. L. 111–152, title I, § 1302, Mar. 30, 2010, 124 Stat. 1057; Pub. L. 114–10, title V, §§ 505(a), 509(a), (c), Apr. 16, 2015, 129 Stat. 166, 170; Pub. L. 114–115, § 7(a), Dec. 28, 2015, 129 Stat. 3134.)

Editorial Notes

REFERENCES IN TEXT

Section 3544 of title 44, referred to in subsec. (e)(1), (2)(C)(iii), was repealed by Pub. L. 113–283, § 2(a), Dec. 18, 2014, 128 Stat. 3073. Provisions similar to section 3544 of title 44 are now contained in section 3554 of title 44, as enacted by Pub. L. 113–283.

CODIFICATION

In subsec. (b)(1)(B), ''section 6101 of title 41'' substituted for ''section 5 of title 41, United States Code,'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2015—Subsec. (a)(4)(G), (H). Pub. L. 114–10, § 505(a)(1), added subpar. (G) and redesignated former subpar. (G) as (H).

Subsec. (b)(1)(B). Pub. L. 114–10, § 509(a), substituted ''10 years'' for ''5 years''.

Subsec. (b)(1)(D). Pub. L. 114–115 designated existing provisions as cl. (i) and inserted heading, substituted ''Subject to clauses (ii) and (iii), the Secretary'' for ''The Secretary'', and added cls. (ii) and (iii).

Subsec. (b)(3)(A)(iv). Pub. L. 114–10, § 509(c), added cl. (iv).

Subsec. (h). Pub. L. 114–10, § 505(a)(2), added subsec. (h).

2010—Subsec. (h). Pub. L. 111–152 struck out subsec. (h) which related to conduct of prepayment review.

2003—Subsec. (b)(3)(A)(i). Pub. L. 108–173, § 940A(b), inserted at end ''Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.''

Subsec. (e). Pub. L. 108–173, § 912(a), added subsec. (e).

Subsec. (f). Pub. L. 108–173, § 921(b)(1), added subsec. (f).

Subsec. (g). Pub. L. 108–173, § 921(c)(1), added subsec. (g).

Subsec. (h). Pub. L. 108–173, § 934(a), added subsec. (h).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–115, § 7(b), Dec. 28, 2015, 129 Stat. 3134, provided that:

''(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall apply to contracts entered into or renewed on or after the date that is 3 years after the date of enactment of this Act [Dec. 28, 2015].

''(2) APPLICATION TO EXISTING CONTRACTS.—In the case of contracts in existence on or after the date of the enactment of this Act and that are not subject to the effective date under paragraph (1), the Secretary of Health and Human Services shall, when appropriate and practicable, seek to apply the incentives provided for in the amendments made by subsection (a) through contract modifications.''

Pub. L. 114–10, title V, § 509(b), Apr. 16, 2015, 129 Stat. 170, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to contracts entered into on or after, and to contracts in effect as of, the date of the enactment of this Act [Apr. 16, 2015].''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 921(c)(2), Dec. 8, 2003, 117 Stat. 2390, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect October 1, 2004.''

Pub. L. 108–173, title IX, § 934(b), Dec. 8, 2003, 117 Stat. 2407, provided that:

''(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Dec. 8, 2003].

''(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary [of Health and Human Services] shall first issue regulations under section 1874A(h) of the Social Security Act [42 U.S.C. 1395kk–1(h)], as added by subsection (a), by not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003].

''(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act [42 U.S.C. 1395kk–1(h)(1)(B)], as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]) as the Secretary shall specify.''

EFFECTIVE DATE; TRANSITION RULE

Pub. L. 108–173, title IX, § 911(d), Dec. 8, 2003, 117 Stat. 2385, provided that:

''(1) EFFECTIVE DATE.—

''(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title] shall take effect on October 1, 2005, and the Secretary [of Health and Human Services] is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

''(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act [see Tables for classification], other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

''(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

''(2) GENERAL TRANSITION RULES.—

''(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to October 1, 2005, the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 prior to October 1, 2005, without regard to any of the provider nomination provisions of such section.

''(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A [42 U.S.C. 1395kk–1], as added by subsection (a)(1).

''(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—Notwithstanding the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title], the provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act [Dec. 8, 2003] and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act [42 U.S.C. 1395kk–1], as inserted by subsection (a)(1), that continues the activities referred to in such provisions.''

CONSTRUCTION

Pub. L. 108–173, title IX, § 901(a), Dec. 8, 2003, 117 Stat. 2374, provided that: ''Nothing in this title [see Tables for classification] shall be construed—

''(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly known as the 'False Claims Act'); or

''(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this division [Pub. L. 108–173 does not contain any divisions] does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.''

CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS

Pub. L. 108–173, title IX, § 911(a)(2), Dec. 8, 2003, 117 Stat. 2383, provided that: ''In developing contract performance requirements under section 1874A(b) of the Social Security Act [42 U.S.C. 1395kk–1(b)], as inserted by paragraph (1), the Secretary [of Health and Human Services] shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act [42 U.S.C. 1395h(f)(2)] (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act [42 U.S.C. 1395u(b)(2)(B)] (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act [Dec. 8, 2003].''

REFERENCES

Pub. L. 108–173, title IX, § 911(e), Dec. 8, 2003, 117 Stat. 2386, provided that: ''On and after the effective date provided under subsection (d)(1) [set out above], any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act [42 U.S.C. 1395kk–1]).''

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 108–173, title IX, § 911(f), Dec. 8, 2003, 117 Stat. 2386, provided that: ''Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section [enacting this section, amending sections 1395h and 1395u of this title, and enacting provisions set out as notes under this section].''

REPORTS ON IMPLEMENTATION

Pub. L. 108–173, title IX, § 911(g), Dec. 8, 2003, 117 Stat. 2386, provided that:

''(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary [of Health and Human Services] shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title]. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

''(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

''(A) The number of contracts that have been competitively bid as of such date.

''(B) The distribution of functions among contracts and contractors.

''(C) A timeline for complete transition to full competition.

''(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.''

APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS

Pub. L. 108–173, title IX, § 912(b), Dec. 8, 2003, 117 Stat. 2388, provided that:

''(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act [42 U.S.C. 1395kk–1(e)(2)] (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

''(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act [Dec. 8, 2003], the first evaluation under section 1874A(e)(2)(A) of the Social Security Act [42 U.S.C. 1395kk–1(e)(2)(A)] (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary [of Health and Human Services]) by not later than 1 year after such date.''

Pub. L. 108–173, title IX, § 921(b)(2), Dec. 8, 2003, 117 Stat. 2389, provided that: ''The provisions of section 1874A(f) of the Social Security Act [42 U.S.C. 1395kk–1(f)], as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.''

Pub. L. 108–173, title IX, § 921(c)(3), Dec. 8, 2003, 117 Stat. 2390, provided that: ''The provisions of section 1874A(g) of the Social Security Act [42 U.S.C. 1395kk–1(g)], as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.''

Pub. L. 108–173, title IX, §934(c), Dec. 8, 2003, 117 Stat. 2407, provided that: ''The provisions of section 1874A(h) of the Social Security Act [42 U.S.C. 1395kk–1(h)], as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.''

POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES

Pub. L. 108–173, title IX, §941, Dec. 8, 2003, 117 Stat. 2418, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the [sic] title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] on or after the date of the enactment of this Act [Dec. 8, 2003] unless the Secretary—

''(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

''(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

''(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

''(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

''(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

''(b) PILOT PROJECTS TO TEST MODIFIED OR NEW EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

''(1) IN GENERAL.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

''(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

''(A) be voluntary;

''(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

''(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

''(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

''(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

''(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

''(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

''(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

''(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the proposed guidelines on—

''(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

''(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

''(5) REPORT ON PILOT PROJECTS.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

''(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

''(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

''(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

''(3) increase accuracy by reviewers; and

''(4) educate both physicians and reviewers.

''(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

''(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

''(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

''(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

''(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

''(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

''(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.].

''(5) REPORT TO CONGRESS.—

''(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

''(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

''(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

''(f) DEFINITIONS.—In this section—

''(1) the term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

''(2) the term 'teaching settings' are those settings described in section 415.150 of title 42, Code of Federal Regulations.''

§ 1395kk–2. Expanding availability of Medicare data

(a) Expanding uses of Medicare data by qualified entities

(1) Additional analyses

(A) In general

Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) Limitations with respect to analyses

(i) Employers

Any analyses provided or sold under subparagraph (A) to an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) Health insurance issuers

A qualified entity may not provide or sell an analysis to a health insurance issuer described in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) Access to certain data

(A) Access

To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v),[1] of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

[1] So in original. The comma probably should not appear.

(B) Purposes described

The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) Medicare claims data must be provided at no cost

A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) Protection of information

(A) In general

Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) Information on patients of the provider of services or supplier

To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) Prohibition on using analyses or data for marketing purposes

An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(4) Data use agreement

A qualified entity and an authorized user described in clauses (i), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to the authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(5) No redisclosure of analyses or data

(A) In general

Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) Permitted redisclosure

A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(6) Opportunity for providers of services and suppliers to review

Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) Assessment for a breach

(A) In general

In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) Assessment

The assessment under subparagraph (A) shall be an amount up to $100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled for benefits under part B of such title [42 U.S.C. 1395j et seq.]—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) Deposit of amounts collected

Any amounts collected pursuant to this paragraph shall be deposited in Federal[2] Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(8) Annual reports

Any qualified entity that provides or sells an analysis or data under paragraph (1) or (2) shall annually submit to the Secretary a report that includes—

(A) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) Definitions

In this subsection and subsection (b):

(A) Authorized user

The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 1002(5) of title 29).

(iv) A health insurance issuer (as defined in section 300gg–91 of this title).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) Provider of services

The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(C) Qualified entity

The term ''qualified entity'' has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).[3]

(D) Secretary

The term ''Secretary'' means the Secretary of Health and Human Services.

(E) Supplier

The term ''supplier'' has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(b) Access to Medicare data by qualified clinical data registries to facilitate quality improvement

(1) Access

(A) In general

To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2016, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient

[2] So in original. Probably should be preceded by ''the''.

[3] So in original. Probably should be ''1395kk(e)(2)).''

safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) Data described

The data described in this subparagraph is—

(i) claims data under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] and the State Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.].

(2) Fee

Data described in paragraph (1)(B) shall be provided to a qualified clinical data registry under paragraph (1) at a fee equal to the cost of providing such data. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

(Pub. L. 114–10, title I, §105, Apr. 16, 2015, 129 Stat. 133.)

Editorial Notes

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(4), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

The Social Security Act, referred to in subsecs. (a)(7)(B) and (b)(1)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to this subchapter and subchapters XIX (§1396 et seq.) and XXI (§1397aa et seq.) of this chapter, respectively. Parts A and B of title XVIII of the Act are classified generally to parts A (§1395c et seq.) and B (§1395j et seq.) of this subchapter, respectively. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section is comprised of section 105 of Pub. L. 114–10. Subsecs. (c) and (d) of section 105 of Pub. L. 114–10 amended section 1395kk of this title.

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Social Security Act which comprises this chapter.

§ 1395*ll*. Studies and recommendations

(a) Health care of the aged and disabled

The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B of this subchapter; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) Operation and administration of insurance programs

The Secretary shall make a continuing study of the operation and administration of this subchapter (including a validation of the accreditation process of national accreditation bodies under section 1395bb(a) of this title[1] the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972 [42 U.S.C. 1395mm], the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1] and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note]), and shall transmit to the Congress annually a report concerning the operation of such programs.

(Aug. 14, 1935, ch. 531, title XVIII, §1875, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 332; amended Pub. L. 90–248, title IV, §402(c), Jan. 2, 1968, 81 Stat. 931; Pub. L. 92–603, title II, §§201(c)(7), 222(c), 226(d), 244(d), Oct. 30, 1972, 86 Stat. 1373, 1393, 1404, 1423; Pub. L. 98–369, div. B, title III, §2354(b)(17), July 18, 1984, 98 Stat. 1101; Pub. L. 99–509, title IX, §9316(a), Oct. 21, 1986, 100 Stat. 2006; Pub. L. 100–203, title IV, §4085(i)(20), Dec. 22, 1987, 101 Stat. 1330–133; Pub. L. 100–647, title VIII, §8413, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–234, title III, §301(b)(5), (d)(2), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101–239, title VI, §6103(b)(3)(A), Dec. 19, 1989, 103 Stat. 2199; Pub. L. 108–173, title I, §101(e)(7), Dec. 8, 2003, 117 Stat. 2152; Pub. L. 110–275, title I, §125(b)(4), July 15, 2008, 122 Stat. 2519.)

Editorial Notes

REFERENCES IN TEXT

Section 226 of the Social Security Amendments of 1972, referred to in subsec. (b), is section 226 of Pub. L. 92–603, which enacted section 1395mm of this title and provisions set out as notes under that section and amended this section and sections 1395f, 1395*l*, and 1396b of this title.

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b), is section 402 of Pub. L. 90–248, which enacted section 1395b–1 of this title and amended this section.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b), is section 222(a) of Pub. L. 92–603, which enacted provisions set out as note under section 1395b–1 of this title.

AMENDMENTS

2008—Subsec. (b). Pub. L. 110–275 substituted ''national accreditation bodies under section 1395bb(a) of this title'' for ''the Joint Commission on Accreditation of Hospitals,''.

2003—Subsec. (b). Pub. L. 108–173 substituted ''this subchapter'' for ''the insurance programs under parts A and B of this subchapter''.

1989—Subsec. (c). Pub. L. 101–239 struck out subsec. (c) which related to patient outcome assessment research program.

[1] So in original. Probably should be followed by a comma.

Subsec. (c)(7). Pub. L. 101–234, §301(b)(5), (d)(2), amended par. (7) identically, substituting ''date of the enactment of this section'' for ''date of the enactment of this Act''.

1988—Subsec. (c)(3). Pub. L. 100–647 amended par. (3) generally. Prior to amendment, par. (3) read as follows: ''For purposes of carrying out the research program, there are authorized to be appropriated—

''(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

''(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal year 1987 and $2,500,000 for each of fiscal years 1988 and 1989.''

1987—Subsec. (c)(3)(B). Pub. L. 100–203 substituted ''fiscal year 1987'' for ''fiscal years 1987''.

1986—Subsec. (c). Pub. L. 99–509 added subsec. (c).

1984—Subsec. (b). Pub. L. 98–369 struck out ''the'' after ''Joint Commission on''.

1972—Subsec. (a). Pub. L. 92–603, §201(c)(7), inserted ''and the disabled'' after ''aged''.

Subsec. (b). Pub. L. 92–603, §§222(c), 226(d)(1), 244(d), substituted ''(including a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972, the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972)'' for ''(including the experimentation authorized by section 402 of the Social Security Amendments of 1967)''. Pub. L. 92–603, §226(d)(2), which directed the substitution of ''1972'' for ''1971'', could not be executed because ''1971'' did not appear.

1968—Subsec. (b). Pub. L. 90–248 inserted ''(including the experimentation authorized by section 402 of the Social Security Amendments of 1967'' after ''under parts A and B of this subchapter''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Amendment by Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as a note under section 1395bb of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6103(b)(3)(A), Dec. 19, 1989, 103 Stat. 2199, provided that the amendment made by that section is effective for fiscal years beginning after fiscal year 1990.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 226(d) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES

Pub. L. 108–173, title II, §238, Dec. 8, 2003, 117 Stat. 2213, provided that:

''(a) EVALUATION.—

''(1) IN GENERAL.—Not later than the date that is 2 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the 'Institute') shall conduct an evaluation of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

''(A) catalogue, review, and evaluate the validity of leading health care performance measures;

''(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

''(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

''(i) the performance measurement set to be used and how that measurement set will be updated;

''(ii) the payment policy that will reward performance; and

''(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

''(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, other health care providers, health plans, purchasers, and patients.

''(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

''(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act [Dec. 8, 2003], the Institute shall submit to the Secretary and appropriate committees of jurisdiction of the Senate and House of Representatives a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance, including options for updating performance measures, in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], the Medicare Advantage program under part C of such title [42 U.S.C. 1395w–21 et seq.], and any other programs under such title XVIII [42 U.S.C. 1395 et seq.].

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for purposes of conducting the evaluation and preparing the report required by this section.''

GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §604, Dec. 8, 2003, 117 Stat. 2301, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

''(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program [42 U.S.C. 1395j et seq.];

''(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

''(3) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

''(1) data from claims submitted by physicians under part B of the medicare program [42 U.S.C. 1395j et seq.] indicate potential access problems for medicare beneficiaries in certain geographic areas; and

''(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.''

STUDY ON ENROLLMENT PROCEDURES FOR GROUPS THAT RETAIN INDEPENDENT CONTRACTOR PHYSICIANS

Pub. L. 106–554, §1(a)(6) [title IV, §413], Dec. 21, 2000, 114 Stat. 2763, 2763A–515, provided that:

''(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current medicare enrollment process for groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. In conducting the evaluation, the Comptroller General shall consult with groups that retain independent contractor physicians and shall—

''(1) review the issuance of individual medicare provider numbers and the possible medicare program integrity vulnerabilities of the current process;

''(2) review direct and indirect costs associated with the current process incurred by the medicare program and groups that retain independent contractor physicians;

''(3) assess the effect on program integrity by the enrollment of groups that retain independent contractor hospital-based physicians; and

''(4) develop suggested procedures for the enrollment of these groups.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a).''

GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS

Pub. L. 106–554, §1(a)(6) [title IV, §437], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

''(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study on the post-payment audit process under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as such process applies to physicians, including the proper level of resources that the Health Care Financing Administration should devote to educating physicians regarding—

''(A) coding and billing;

''(B) documentation requirements; and

''(C) the calculation of overpayments.

''(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

''(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations regarding any area in which—

''(A) a reduction in paperwork, an ease of administration, or an appropriate change in oversight and review may be accomplished; or

''(B) additional payments or education are needed to assist physicians and other health care providers in understanding and complying with any legal or regulatory requirements.''

STUDY AND REPORT REGARDING UTILIZATION OF PHYSICIANS' SERVICES BY MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–349, provided that:

''(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

''(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are the following:

''(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) [42 U.S.C. 1395c et seq., 1395j et seq.] resulting from—

''(i) improvements in medical capabilities;

''(ii) advancements in scientific technology;

''(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

''(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

''(B) The rate of usage of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

''(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act [Nov. 29, 1999], the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

''(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

''(A) an analysis and evaluation of the report submitted under paragraph (3); and

''(B) such recommendations as it determines are appropriate.''

STUDY OF ADULT DAY CARE SERVICES

Pub. L. 100–360, title II, §208, July 1, 1988, 102 Stat. 732, as amended by Pub. L. 100–485, title VI, §608(d)(8), Oct. 13, 1988, 102 Stat. 2415, directed Secretary of Health and Human Services to conduct a survey of adult day care services in United States and to report to Congress, by not later than 1 year after July 1, 1988, on the information collected in the survey, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE

Pub. L. 99–509, title IX, §9313(d), Oct. 21, 1986, 100 Stat. 2004, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(A), Dec. 22, 1987, 101 Stat. 1330–133, directed Secretary of Health and Human Services to arrange, with the National Academy of Sciences or other appropriate nonprofit private entity, for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under this subchapter, specified items to be included in the study, and di-

rected Secretary to submit to Congress, not later than Jan. 1, 1990, a report on the study with recommendations with respect to strengthening quality assurances and review activities for services furnished under the medicare program.

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of waiver, see section 9202(j) of Pub. L. 99–272, as amended, set out as a note under section 1395ww of this title.

DRUG DETOXIFICATION MEDICARE COVERAGE AND FACILITY INCENTIVES

Pub. L. 96–499, title IX, § 931(f), Dec. 5, 1980, 94 Stat. 2634, which related to a study of medicare coverage of certain additional detoxification-related services, was repealed by Pub. L. 97–35, title XXI, § 2121(h), Aug. 13, 1981, 95 Stat. 796.

LEGISLATIVE RECOMMENDATIONS REGARDING REIMBURSEMENT FOR OPTOMETRISTS' SERVICES

Pub. L. 96–499, title IX, § 937(b), Dec. 5, 1980, 94 Stat. 2640, provided that the Secretary of Health and Human Services submit to the Congress by Jan. 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

DEMONSTRATION PROJECTS, STUDIES, AND REPORTS: NUTRITIONAL THERAPY, SECOND OPINION COST-SHARING, SERVICES OF REGISTERED DIETITIANS, SERVICES OF CLINICAL SOCIAL WORKERS, ORTHOPEDIC SHOES, RESPIRATORY THERAPY SERVICES, AND FOOT CONDITIONS; GRANTS, PAYMENTS, AND EXPENDITURES

Pub. L. 96–499, title IX, § 958, Dec. 5, 1980, 94 Stat. 2648, directed Secretary of Health and Human Services to carry out certain demonstration projects and conduct certain studies as follows: (a) a demonstration project to determine extent to which nutritional therapy in early renal failure could retard the disease with resultant substantive deferment of dialysis, and aspects of making such therapy available under this subchapter, report to Congress to be submitted within twenty-four months of Dec. 5, 1980; (b) demonstration projects with respect to waiving the applicable cost sharing amounts which beneficiaries under this subchapter had to pay for obtaining a second opinion on having surgery, report to be submitted within one year after Dec. 5, 1980; (c) a study of conditions under which services of registered dietitians could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (d) demonstration projects to determine aspects of making services of clinical social workers more generally available under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (e) a study of methods for providing coverage under part B of this subchapter for orthopedic shoes for individuals with disabling or deforming conditions requiring special fitting considerations, or requiring special shoes in conjunction with the use of an orthosis or foot support, report to be submitted no later than July 1, 1981; (f) a study of conditions under which services with respect to respiratory therapy could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; and (g) a study analyzing cost effects of alternative approaches to improving coverage under this subchapter for treatment of various types of foot conditions, report to be submitted within twenty-four months of Dec. 5, 1980. Payments and expenditures for such studies and projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund established by section 1395i of this title, and the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title.

DEMONSTRATION PROJECT RELATING TO THE TERMINALLY ILL

Pub. L. 96–265, title V, § 506, June 9, 1980, 94 Stat. 475, authorized Secretary of Health and Human Services to provide for participation, by Social Security Administration, in a demonstration project relating to the terminally ill then being conducted within the Department of Health and Human Services, the purpose of such participation to be to study impact on terminally ill of provisions of disability programs administered by Social Security Administration and to determine how best to provide services needed by persons who were terminally ill through programs over which the Social Security Administration had administrative responsibility, and authorized to be appropriated necessary sums not in excess of $2,000,000 for any fiscal year.

REPORT TO CONGRESS WITH RESPECT TO URBAN OR RURAL COMPREHENSIVE MENTAL HEALTH CENTERS AND CENTERS FOR TREATMENT OF ALCOHOLISM AND DRUG ABUSE; SUBMISSION NO LATER THAN JUNE 13, 1978

Pub. L. 95–210, § 4, Dec. 13, 1977, 91 Stat. 1490, directed Secretary of Health, Education, and Welfare to submit to Congress, no later than six months after Dec. 13, 1977, a report on the advantages and disadvantages of extending coverage under this subchapter to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

STUDY AND REVIEW BY COMPTROLLER GENERAL OF ADMINISTRATIVE STRUCTURE FOR PROCESSING MEDICARE CLAIMS; REPORT TO CONGRESS

Pub. L. 95–142, § 12, Oct. 25, 1977, 91 Stat. 1197, directed Comptroller General to conduct a comprehensive study and review of administrative structure established for processing of claims under this subchapter for purpose of determining whether and to what extent more efficient claims administration under this subchapter could be achieved and directed Comptroller General to submit to Congress no later than July 1, 1979, a complete report with respect to such study and review.

REPORT BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON DELIVERY OF HOME HEALTH AND OTHER IN-HOME SERVICES; CONTENTS; CONSULTATION REQUIREMENTS; SUBMISSION TO CONGRESS

Pub. L. 95–142, § 18, Oct. 25, 1977, 91 Stat. 1202, directed Secretary of Health, Education, and Welfare, not later than one year after Oct. 25, 1977, to submit to appropriate committees of Congress a report analyzing, evaluating, and making recommendations with respect to all aspects of delivery of home health and other in-home services authorized to be provided under subchapters XVIII, XIX, and XX of this chapter.

§ 1395mm. Payments to health maintenance organizations and competitive medical plans

(a) Rates and adjustments

(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term ''risk-sharing contract'' means a contract entered into under subsection (g) and the term ''reasonable cost reimbursement contract'' means a contract entered into under subsection (h).

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

(3) Subject to subsections (c)(2)(B)(ii) and (c)(7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1395f(b) and 1395*l*(a) of this title, for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term ''adjusted average per capita cost'' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1395h and 1395u of this title), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1395x(s)(2)(H) of this title, if the services were to be furnished by a physician or as an incident to a physician's service.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

(6) Subject to subsections (c)(2)(B)(ii) and (c)(7), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(b) Definitions; requirements

For purposes of this section, the term ''eligible organization'' means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 300e–9(d)[1] of this title), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians' services performed by physicians (as defined in section 1395x(r)(1) of this title).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under subchapter XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

(c) Enrollment in plan; duties of organization to enrollees

(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

(2)(A) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI—

(i) only those services covered under parts A and B of this subchapter, for those members entitled to benefits under part A and enrolled under part B, or

(ii) only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (I) the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (II) in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days

[1] See References in Text note below.

duration every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this subchapter for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this subchapter related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this subchapter, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in—

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must—

(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this subchapter as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1395ww(d) of this title, and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(d) Right to enroll with contracting organization in geographic area

Subject to the provisions of subsection (c)(3), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e) Limitation on charges; election of coverage; "adjusted community rate" defined; workmen's compensation and insurance benefits

(1) In no case may—

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled under this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary

finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this subchapter, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term ''adjusted community rate'' for a service or services means, at the election of an eligible organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a ''community rating system'' (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f) Membership requirements

(1) For contract periods beginning before January 1, 1999, each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this subchapter.

(2) Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—

(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this subchapter or under a State plan approved under subchapter XIX, or

(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

(g) Risk-sharing contract

(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b), which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this

section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) The additional benefits referred to in paragraph (2) are—

(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.

(4) Repealed. Pub. L. 100–203, title IV, § 4012(b), Dec. 22, 1987, 101 Stat. 1330–61.

(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

(h) Reasonable cost reimbursement contract; requirements

(1) If—

(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1),

the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1395x(v) of this title) in the manner prescribed in paragraph (3).

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1395x(v) of this title) or for payment amounts determined in accordance with section 1395ww of this title, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1395x(v) of this title) or the amount determined under section 1395ww of this title, as applicable, unless such organization demonstrates to the satisfac-

tion of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1395ww of this title for the types of expenses otherwise reimbursable under this subchapter for providing services covered under this subchapter to individuals described in subsection (a)(1).

(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this subchapter for providing services described in subsection (a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which an eligible organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this subchapter, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(5)(A) After August 5, 1997, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of August 5, 1997), except for a contract with an eligible organization which, immediately previous to entering into such contract, had an agreement in effect under section 1395*l*(a)(1)(A) of this title.

(B) Subject to subparagraph (C), the Secretary shall approve an application for a modification to a reasonable cost contract under this section in order to expand the service area of such contract if—

(i) such application is submitted to the Secretary on or before September 1, 2003; and

(ii) the Secretary determines that the organization with the contract continues to meet the requirements applicable to such organizations and contracts under this section.

(C)(i) Subject to clause (ii), a reasonable cost reimbursement contract under this subsection may be extended or renewed indefinitely.

(ii) Subject to clause (iv), for any period beginning on or after January 1, 2016, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

(I) 2 or more MA regional plans described in clause (iii), provided that all such plans are not offered by the same Medicare Advantage organization; or

(II) 2 or more MA local plans described in clause (iii), provided that all such plans are not offered by the same Medicare Advantage organization.

(iii) A plan described in this clause for a year for a service area is a plan described in section 1395w–21(a)(2)(A)(i) of this title if the service area for the year meets the following minimum enrollment requirements:

(I) With respect to any portion of the cost plan service area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area that are not in another Metropolitan Statistical Area with a population of more than 250,000, 5,000 individuals. If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area).

(II) With respect to any other portion of such cost plan service area, 1,500 individuals.

(iv) In the case of an eligible organization that is offering a reasonable cost reimbursement contract that may no longer be extended or renewed because of the application of clause (ii), or where such contract has been extended or renewed but the eligible organization has informed the Secretary in writing not later than a date determined appropriate by the Secretary that such organization voluntarily plans not to seek renewal of the reasonable cost reimbursement contract, the following shall apply:

(I) Notwithstanding such clause, such contract may be extended or renewed for the two years subsequent to 2016. The final year in which such contract is extended or renewed is referred to in this subsection as the ''last reasonable cost reimbursement contract year for the contract''.

(II) The organization may not enroll a new enrollee under such contract during the last reasonable cost reimbursement contract year

for the contract (but may continue to enroll new enrollees through the end of the year immediately preceding such year) unless such enrollee is any of the following:

(aa) An individual who chooses enrollment in the reasonable cost contract during the annual election period with respect to such last year.

(bb) An individual whose spouse, at the time of the individual's enrollment[2] is an enrollee under the reasonable cost reimbursement contract.

(cc) An individual who is covered under an employer group health plan that offers coverage through the reasonable cost reimbursement contract.

(dd) An individual who becomes entitled to benefits under part A, or enrolled under part B, and was enrolled in a plan offered by the eligible organization immediately prior to the individual's enrollment under the reasonable cost reimbursement contract.

(III) Not later than a date determined appropriate by the Secretary prior to the beginning of the last reasonable cost reimbursement contract year for the contract, the organization shall provide notice to the Secretary as to whether the organization will apply to have the contract converted over, in whole or in part, and offered as a Medicare Advantage plan under part C for the year following the last reasonable cost reimbursement contract year for the contract.

(IV) If the organization provides the notice described in subclause (III) that the contract will be converted, in whole or in part, the organization shall, not later than a date determined appropriate by the Secretary, provide the Secretary with such information as the Secretary determines appropriate in order to carry out section 1395w–21(c)(4) of this title and to carry out section 1395w–24(a)(5) of this title, including subparagraph (C)(ii) of such section.

(V) In the case that the organization enrolls a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract, the organization shall provide the individual with a notification that such year is the last year for such contract.

(v) If an eligible organization that is offering a reasonable cost reimbursement contract that is extended or renewed pursuant to clause (iv) provides the notice described in clause (iv)(III) that the contract will be converted, in whole or in part, the following shall apply:

(I) The deemed enrollment under section 1395w–21(c)(4) of this title.

(II) The special rule for quality increase under section 1395w–23(*o*)(4)(C) of this title.

(III) During the last reasonable cost reimbursement contract year for the contract and the year immediately preceding such year, the eligible organization, or the corporate parent organization of the eligible organization, shall be permitted to offer an MA plan in the area that such contract is being offered and enroll Medicare Advantage eligible individuals in such MA plan and such cost plan.

[2] So in original. Probably should be followed by a comma.

(i) Duration, termination, effective date, and terms of contract; powers and duties of Secretary

(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(3) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled under this section with the organization; and

(C)(i) shall require the organization to comply with subsections (a) and (c) of section 300e–17 of this title (relating to disclosure of certain financial information) and with the requirement of section 300e(c)(8)[1] of this title (relating to liability arrangements to protect members);

(ii) shall require the organization to provide and supply information (described in section 1395cc(b)(2)(C)(ii) of this title) in the manner such information is required to be provided or supplied under that section;

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

(D) shall contain such other terms and conditions not inconsistent with this section (in-

cluding requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(v) misrepresents or falsifies information that is furnished—

(I) to the Secretary under this section, or

(II) to an individual or to any other entity under this section;

(vi) fails to comply with the requirements of subsection (g)(6)(A) or paragraph (8); or

(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a–7 or 1320a–7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain a written agreement with a quality improvement organization (which has a contract with the Secretary under part B of subchapter XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1320c–3(a)(4)(C)[1] of this title under which the review organization will perform functions under section 1320c–3(a)(4)(B) of this title and section 1320c–3(a)(14) of this title (other than those performed under contracts described in section 1395cc(a)(1)(F) of this title) with respect to services, furnished by the eligible organization, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this subchapter and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of subchapter XI.

(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) In this paragraph, the term ''physician incentive plan'' means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

(j) Payment in full and limitation on actual charges; physicians, providers of services, or renal dialysis facilities not under contract with organization

(1)(A) In the case of physicians' services or renal dialysis services described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with an eligible organization under this section and enrolled under part B, the applicable participation agreement is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services or renal dialysis services described in this paragraph are physicians' services or renal dialysis services which are furnished to an enrollee of an eligible organization under this section by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.

(k) Risk-sharing contracts

(1) Except as provided in paragraph (2)—

(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1395w–26(b)(1) of

this title, the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization; and

(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1395w–26(b)(1) of this title.

(3) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1395w–23(a) of this title for the payment rates otherwise established under subsection (a), and

(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this subchapter attributable to such part) for the payment rates otherwise established under subsection (a).

(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C:

(A) Data collection requirements under section 1395w–23(a)(3)(B) of this title.

(B) Restrictions on imposition of premium taxes under section 1395w–24(g) of this title in relating to payments to such organizations under this section.

(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1395w–21(e)(6) of this title.

(D) Payments under section 1395w–27(e)(2) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1876, as added and amended Pub. L. 92–603, title II, §§ 226(a), 278(b)(3), Oct. 30, 1972, 86 Stat. 1396, 1453; Pub. L. 93–233, § 18(m), (n), Dec. 31, 1973, 87 Stat. 970, 971; Pub. L. 94–460, title II, § 201(a)–(d), Oct. 8, 1976, 90 Stat. 1956, 1957; Pub. L. 95–292, § 5, June 13, 1978, 92 Stat. 315; Pub. L. 97–248, title I, § 114(a), Sept. 3, 1982, 96 Stat. 341; Pub. L. 97–448, title III, § 309(b)(12), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§ 602(g), 606(a)(3)(H), Apr. 20, 1983, 97 Stat. 164, 171; Pub. L. 98–369, div. B, title III, §§ 2350(a)(1), (b)(1), (2), (c), 2354(b)(37), (38), July 18, 1984, 98 Stat. 1097, 1098, 1102; Pub. L. 99–272, title IX, § 9211(a)–(d), Apr. 7, 1986, 100 Stat. 178, 179; Pub. L. 99–509, title IX, §§ 9312(b)(1), (c)(1), (2), (d)(1), (e)(1), (f), 9353(e)(2), Oct. 21, 1986, 100 Stat. 1999–2001, 2048; Pub. L. 99–514, title XVIII, § 1895(b)(11)(A), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 100–203, title IV, §§ 4011(a)(1), (b)(1), 4012(b), 4013(a), 4014, 4018(a), 4039(h)(8), Dec. 22, 1987, 101 Stat. 1330–60, 1330–61, 1330–65, as amended Pub. L. 100–360, title IV, § 411(c)(3), (e)(3), July 1, 1988, 102 Stat. 773, 776; Pub. L. 100–360, title II, §§ 202(f), 211(c)(3), 224, title IV, § 411(c)(1), (4), (6), formerly (5), July 1, 1988, 102 Stat. 717, 738, 748, 772, 773, as amended Pub. L. 100–485, title VI, § 608(d)(19)(B), (C), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 100–647, title VIII, § 8412(a)(1), Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–234, title II, §§ 201(a), 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6206(a)(1), (b)(1), 6212(b)(1), (c)(2), 6411(d)(3)(A), Dec. 19, 1989, 103 Stat. 2244, 2250, 2271; Pub. L. 101–508, title IV, §§ 4204(a)(1), (2), (c)(1), (2), (d)(1), (e)(1), 4206(b)(1), Nov. 5, 1990, 104 Stat. 1388–108 to 1388–111, 1388–116; Pub. L. 103–296, title I, § 108(c)(6), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 103–432, title I, § 157(b)(1), (4), Oct. 31, 1994, 108 Stat. 4442; Pub. L. 104–191, title II, §§ 215(a), (b), 231(g), Aug. 21, 1996, 110 Stat. 2005–2007, 2014; Pub. L. 105–33, title IV, § 4002(a)–(b)(2)(A), Aug. 5, 1997, 111 Stat. 328, 329; Pub. L. 106–113, div. B, 1000(a)(6) [title V, § 503], Nov. 29, 1999, 113 Stat. 1536, 1501A–380; Pub. L. 106–554, § 1(a)(6) [title VI, § 634], Dec. 21, 2000, 114 Stat. 2763, 2763A–568; Pub. L. 108–173, title II, § 234, title VII, § 736(d)(2), title IX, § 940(b)(2)(B), Dec. 8, 2003, 117 Stat. 2209, 2357, 2417; Pub. L. 110–173, title I, § 109, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, § 167(a)–(c), July 15, 2008, 122 Stat. 2575, 2576; Pub. L. 111–148, title III, § 3206, Mar. 23, 2010, 124 Stat. 459; Pub. L. 112–40, title II, § 261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–240, title VI, § 608, Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, § 1108, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, § 108, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, § 209(a), Apr. 16, 2015, 129 Stat. 146.)

Editorial Notes

REFERENCES IN TEXT

Section 300e–9(d) of this title, referred to in subsec. (b)(1), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, § 7(b), Oct. 24, 1988, 102 Stat. 2580.

Section 300e(c)(8) of this title, referred to in subsec. (i)(3)(C)(i), was redesignated section 300e(c)(7) of this title by Pub. L. 100–517, § 5(b), Oct. 24, 1988, 102 Stat. 2579.

Section 1320c–3(a)(4)(C) of this title, referred to in subsec. (i)(7)(A), was repealed by Pub. L. 112–40, title II, § 261(c)(2)(A)(ii), Oct. 21, 2011, 125 Stat. 425.

AMENDMENTS

2015—Subsec. (h)(5)(C)(ii). Pub. L. 114–10, § 209(a)(1), substituted ''Subject to clause (iv), for any'' for ''For any'' in introductory provisions.

Subsec. (h)(5)(C)(iii)(I). Pub. L. 114–10, § 209(a)(2), inserted ''cost plan service'' after ''With respect to any portion of the''.

Subsec. (h)(5)(C)(iii)(II). Pub. L. 114–10, § 209(a)(3), inserted ''cost plan service'' after ''With respect to any other portion of such'' in introductory provisions.

Subsec. (h)(5)(C)(iv), (v). Pub. L. 114–10, § 209(a)(4), added cls. (iv) and (v).

2014—Subsec. (h)(5)(C)(ii). Pub. L. 113–93 substituted ''January 1, 2016'' for ''January 1, 2015'' in introductory provisions.

2013—Subsec. (h)(5)(C)(ii). Pub. L. 113–67 substituted ''January 1, 2015'' for ''January 1, 2014'' in introductory provisions.

Pub. L. 112–240 substituted ''January 1, 2014'' for ''January 1, 2013'' in introductory provisions.

2011—Subsec. (i)(7)(A). Pub. L. 112–40 substituted ''quality improvement'' for ''utilization and quality control peer review''.

2010—Subsec. (h)(5)(C)(ii). Pub. L. 111–148 substituted ''January 1, 2013'' for ''January 1, 2010'' in introductory provisions.

2008—Subsec. (h)(5)(C)(ii). Pub. L. 110–275, § 167(a), substituted ''January 1, 2010'' for ''January 1, 2009'' in introductory provisions.

Subsec. (h)(5)(C)(ii)(I), (II). Pub. L. 110–275, § 167(b), inserted '', provided that all such plans are not offered by the same Medicare Advantage organization'' after ''clause (iii)''.

Subsec. (h)(5)(C)(iii)(I). Pub. L. 110–275, § 167(c), inserted ''that are not in another Metropolitan Statistical Area with a population of more than 250,000'' after ''such Metropolitan Statistical Area'' and inserted ''If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area).'' at end.

2007—Subsec. (h)(5)(C)(ii). Pub. L. 110–173 substituted ''January 1, 2009'' for ''January 1, 2008'' in introductory provisions.

2003—Subsec. (c)(2)(B). Pub. L. 108–173, § 736(d)(2)(A), substituted ''significant'' for ''signifcant'' in introductory provisions.

Subsec. (c)(5)(B). Pub. L. 108–173, § 940(b)(2)(B), which directed amendment of subsec. (b)(5)(B) by inserting at end ''The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.'', was executed by making the insertion at end of subsec. (c)(5)(B), to reflect the probable intent of Congress. Subsec. (b) does not contain a par. (5)(B).

Subsec. (h)(5)(C). Pub. L. 108–173, § 234, amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2004.''

Subsec. (j)(2). Pub. L. 108–173, § 736(d)(2)(B), substituted ''this section'' for ''this setion''.

2000—Subsec. (h)(5)(B), (C). Pub. L. 106–554 added subpar. (B) and redesignated former subpar. (B) as (C).

1999—Subsec. (h)(5)(B). Pub. L. 106–113 substituted ''2004'' for ''2002''.

1997—Subsec. (f)(1). Pub. L. 105–33, § 4002(a)(1), substituted ''For contract periods beginning before January 1, 1999, each'' for ''Each'' and struck out ''or under a State plan approved under subchapter XIX of this chapter'' before period at end.

Subsec. (f)(2). Pub. L. 105–33, § 4002(a)(2), substituted ''Subject to paragraph (4), the Secretary'' for ''The Secretary''.

Subsec. (f)(4). Pub. L. 105–33, § 4002(a)(3), added par. (4).

Subsec. (h)(5). Pub. L. 105–33, § 4002(b)(2)(A), added par. (5).

Subsec. (k). Pub. L. 105–33, § 4002(b)(1), added subsec. (k).

1996—Subsec. (i)(1). Pub. L. 104–191, § 215(a)(1), substituted ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—'' for ''the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—'' in introductory provisions, added subpars. (A) to (C), and struck out former subpars. (A) to (C) which read as follows:

''(A) has failed substantially to carry out the contract,

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f) of this section.''

Subsec. (i)(6)(B). Pub. L. 104–191, § 215(a)(4), struck out concluding provisions which read as follows: ''The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (i)(6)(C). Pub. L. 104–191, § 215(a)(2), added subpar. (C).

Subsec. (i)(6)(D). Pub. L. 104–191, § 231(g), added subpar. (D).

Subsec. (i)(7)(A). Pub. L. 104–191, § 215(b), substituted ''a written agreement'' for ''an agreement''.

Subsec. (i)(9). Pub. L. 104–191, § 215(a)(3), added par. (9).

1994—Subsec. (a)(1)(E)(ii)(I). Pub. L. 103–432, § 157(b)(4), struck out comma after ''contributed to''.

Subsec. (a)(3). Pub. L. 103–432, § 157(b)(1), substituted ''subsections (c)(2)(B)(ii) and (c)(7)'' for ''subsection (c)(7)''.

Subsec. (c)(5)(B). Pub. L. 103–296 inserted at end ''In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.''

1990—Subsec. (a)(1)(E). Pub. L. 101–508, § 4204(e)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(6). Pub. L. 101–508, § 4204(c)(2), substituted ''subsections (c)(2)(B)(ii) and (c)(7)'' for ''subsection (c)(7)''.

Subsec. (c)(2). Pub. L. 101–508, § 4204(c)(1), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) and former cls. (i) and (ii) as cls. (i) and (ii) and subcls. (I) and (II), respectively, and added subpar. (B).

Subsec. (c)(8). Pub. L. 101–508, § 4206(b)(1), added par. (8).

Subsec. (i)(6)(A)(vi). Pub. L. 101–508, § 4204(a)(2), inserted ''or paragraph (8)'' after ''(g)(6)(A)''.

Subsec. (i)(8). Pub. L. 101–508, § 4204(a)(1), added par. (8).

Subsec. (j)(1)(A). Pub. L. 101–508, § 4204(d)(1)(A), substituted ''physicians' services or renal dialysis services'' for ''physicians' services'', ''physician or provider of services or renal dialysis facility'' for ''physician'' in three places, and ''applicable participation agreement'' for ''participation agreement under section 1395u(h)(1) of this title''.

Subsec. (j)(2). Pub. L. 101–508, § 4204(d)(1)(B), substituted ''physicians' services or renal dialysis services'' for ''physicians' services'' in two places and ''which are furnished to an enrollee of an eligible organization under this setion [sic] by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.'' for ''which—'' and subpars. (A) and (B) which read as follows:

''(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A) of this section), and

''(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.''

1989—Subsec. (a)(1)(F). Pub. L. 101–239, § 6206(a)(1), added subpar. (F).

Subsec. (a)(5). Pub. L. 101–234, § 202(a), repealed Pub. L. 100–360, § 211(c)(3)(A), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (c)(3)(A)(i). Pub. L. 101–239, § 6206(b)(1)(A), substituted ''period or periods'' for ''30-day period''.

Subsec. (c)(3)(A)(ii). Pub. L. 101–239, § 6206(b)(1)(B), added cl. (ii) and struck out former cl. (ii) which read as follows: ''For each area served by more than one eligible organization under this section, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which

all eligible organizations serving the area must provide for open enrollment under this section. The Secretary shall determine annual per capita rates under subsection (a)(1)(A) of this section in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased for 12 months beginning on the date the individual's enrollment becomes effective. An eligible organization may provide for such other open enrollment period or periods as it deems appropriate consistent with this section.''

Subsecs. (e)(1), (g)(3)(A). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 202(f), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (g)(5). Pub. L. 101–239, § 6212(c)(2), struck out ''and during a period of not longer than four years'' after first reference to ''Secretary''.

Subsec. (i)(6)(A)(vii). Pub. L. 101–239, § 6411(d)(3)(A), added cl. (vii).

Subsec. (j). Pub. L. 101–239, § 6212(b)(1), added subsec. (j).

1988—Subsec. (a)(5). Pub. L. 100–360, § 211(c)(3)(B), amended second sentence generally. Prior to amendment, second sentence read as follows: ''The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

''(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1395r(a)(1) of this title, and

''(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1395r(a)(4) of this title.''

Pub. L. 100–360, § 211(c)(3)(A), substituted '', the Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund'' for ''and the Federal Supplementary Medical Insurance Trust Fund'' in first sentence.

Subsec. (c)(3)(F). Pub. L. 100–360, § 411(c)(1), realigned margin with left margin of subpar. (G).

Subsec. (e)(1). Pub. L. 100–360, § 202(f)(1), inserted at end ''The preceding sentence shall be applied separately with respect to covered outpatient drugs.''

Subsec. (f)(3). Pub. L. 100–647 redesignated par. (4) as (3) and struck out former par. (3) which read as follows: ''(A) An eligible organization described in subparagraph (B) may elect, for purposes of enrollment and residency requirements under this section and for determining the compliance of a subdivision, subsidiary, or affiliate described in subparagraph (B)(iii) with the requirement of paragraph (1) for the period before October 1, 1992, to have members described in subparagraph (B)(iii) who receive services through the subdivision, subsidiary, or affiliate considered to be members of the parent organization.

''(B) An eligible organization described in this subparagraph is an eligible organization which—

''(i) is described in section 1396b(m)(2)(B)(iii) of this title;

''(ii) has members who have a collectively bargained contractual right to obtain health benefits from the organization;

''(iii) elects to provide benefits under a risk-sharing contract to individuals residing in a service area, who have a collectively bargained contractual right to obtain benefits from the organization, through a subdivision, subsidiary, or affiliate which itself is an eligible organization serving the area and which is owned or controlled by the parent eligible organization; and

''(iv) has assumed any risk of insolvency and quality assurance with respect to individuals receiving benefits through such a subdivision, subsidiary, or affiliate.''

Subsec. (f)(3)(A). Pub. L. 100–360, § 411(c)(6), formerly § 411(c)(5), as redesignated by Pub. L. 100–485, § 608(d)(19)(C), inserted ''enrollment and residency requirements under this section and for'' after ''for purposes of'' and substituted ''described in subparagraph (B)(iii) who receives services through the subdivision'' for ''of the subdivision''.

Subsec. (f)(4). Pub. L. 100–647 redesignated par. (4) as (3).

Subsec. (g)(3)(A). Pub. L. 100–360, § 202(f)(2), substituted ''rates'' for ''rate''.

Subsec. (g)(5). Pub. L. 100–360, § 411(c)(3), amended Pub. L. 100–203, § 4013, see 1987 Amendment note below.

Subsec. (i)(6)(A). Pub. L. 100–360, § 411(c)(4)(A), inserted '', in addition to any other remedies authorized by law,'' after ''the Secretary may provide'' in concluding provisions.

Subsec. (i)(6)(B). Pub. L. 100–360, § 411(c)(4)(C), formerly § 411(c)(4)(B), as redesignated by Pub. L. 100–485, § 608(d)(19)(B)(ii), substituted ''or proceeding under section 1320a–7a(a) of this title'' for ''under that section'' in last sentence.

Subsec. (i)(6)(B)(i). Pub. L. 100–360, § 411(c)(4)(B), as added by Pub. L. 100–485, § 608(d)(19)(B)(i), (iii), inserted ''of such subparagraph'' after ''(v)(I)''.

Pub. L. 100–360, § 224, inserted at end ''plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,''.

Subsec. (i)(7)(A). Pub. L. 100–360, § 411(e)(3), added Pub. L. 100–203, § 4039(h)(8)(A), (B), see 1987 Amendment note below.

Subsec. (i)(7)(B). Pub. L. 100–360, § 411(e)(3), added Pub. L. 100–203, § 4039(h)(8)(C), see 1987 Amendment note below.

1987—Subsec. (c)(3)(F). Pub. L. 100–203, § 4011(a)(1), added subpar. (F).

Subsec. (c)(3)(G). Pub. L. 100–203, § 4011(b)(1), added subpar. (G).

Subsec. (f)(3), (4). Pub. L. 100–203, § 4018(a), added par. (3) and redesignated former par. (3) as (4).

Subsec. (g)(4). Pub. L. 100–203, § 4012(b), struck out par. (4) which read as follows: ''A risk-sharing contract under this subsection may, at the option of an eligible organization, provide that the Secretary—

''(A) will reimburse hospitals and skilled nursing facilities either for payment amounts determined in accordance with section 1395ww of this title, or, if applicable, for the reasonable cost (as determined under section 1395x(v) of this title) or other appropriate basis for payment established under this subchapter, of inpatient services furnished to individuals enrolled with such organization pursuant to subsection (d) of this section, and

''(B) will deduct the amount of such reimbursement for payment which would otherwise be made to such organization.''

Subsec. (g)(5). Pub. L. 100–203, § 4013, which directed amendment of par. (5) by substituting ''six years'' for ''four years'', was amended generally by Pub. L. 100–360, § 411(c)(3), so that it does not amend this section.

Subsec. (i)(6). Pub. L. 100–203, § 4014, amended par. (6) generally. Prior to amendment, par. (6) read as follows: ''(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

''(B) The provisions of section 1320a–7a of this title (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as

they apply to a civil money penalty under that section.''

Subsec. (i)(7)(A). Pub. L. 100–203, § 4039(h)(8)(A), (B), as added by Pub. L. 100–360, § 411(e)(3), substituted ''Each'' for ''Except as provided under section 1320c–3(a)(4)(C) of this title, each'', inserted ''or with an entity selected by the Secretary under section 1320c–3(a)(4)(C) of this title'' after ''located)'', and substituted ''which the review organization'' for ''which the peer review organization''.

Subsec. (i)(7)(B). Pub. L. 100–203, § 4039(h)(8)(C), as added by Pub. L. 100–360, § 411(e)(3), substituted ''the review organization'' for ''the peer review organization''.

1986—Subsec. (a)(1)(A). Pub. L. 99–514 substituted ''announce (in a manner intended to provide notice to interested parties)'' for ''publish'' in introductory provisions.

Pub. L. 99–272, § 9211(d), inserted '', and shall publish not later than September 7 before the calendar year concerned'' after ''The Secretary shall annually determine'' in introductory provisions.

Subsec. (a)(3). Pub. L. 99–272, § 9211(a)(2), substituted ''Subject to subsection (c)(7), payments'' for ''Payments''.

Subsec. (a)(6). Pub. L. 99–272, § 9211(a)(3), substituted ''Subject to subsection (c)(7), if'' for ''If''.

Subsec. (c)(3)(B). Pub. L. 99–272, § 9211(b), substituted ''the date on which'' for ''a full calendar month after'', and inserted provision at end that in the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

Subsec. (c)(3)(C). Pub. L. 99–272, § 9211(c), inserted provisions at end that no brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and the Secretary has not disapproved the distribution of the material, and that Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

Subsec. (c)(7). Pub. L. 99–272, § 9211(a)(1), added par. (7).

Subsec. (c)(3)(E). Pub. L. 99–509, § 9312(b)(1), added subpar. (E).

Subsec. (f)(2). Pub. L. 99–509, § 9312(c)(1), struck out ''if the Secretary determines that'' after ''imposed by paragraph (1) only'', added new subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows:

''(A) special circumstances warrant such modification or waiver, and

''(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter.''

Subsec. (f)(3). Pub. L. 99–509, § 9312(c)(2)(A), added par. (3).

Subsec. (g)(6). Pub. L. 99–509, § 9312(d)(1), added par. (6).

Subsec. (i)(1)(C). Pub. L. 99–509, § 9312(c)(3)(B), substituted ''(e), and (f)'' for ''and (e)''.

Subsec. (i)(3)(C). Pub. L. 99–509, § 9312(e)(1), designated existing provisions as cl. (i) and added cls. (ii) and (iii).

Subsec. (i)(6). Pub. L. 99–509, § 9312(f), added par. (6).

Subsec. (i)(7). Pub. L. 99–509, § 9353(e)(2), added par. (7).

1984—Subsec. (b)(2)(D). Pub. L. 98–369, § 2354(b)(37), substituted ''subparagraph (A)'' for ''paragraph (1)''.

Subsec. (c)(3)(A). Pub. L. 98–369, § 2350(a)(1), designated existing provisions as cl. (i), inserted ''and including the 30-day period specified under clause (ii)'' after ''30 days duration every year'', and added cl. (ii).

Subsec. (c)(4)(A)(i). Pub. L. 98–369, § 2354(b)(38), substituted ''with reasonable promptness'' for ''promptly as appropriate''.

Subsec. (g)(2). Pub. L. 98–369, § 2350(b)(1), inserted ''and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5)'' at end of first sentence.

Subsec. (g)(4)(A). Pub. L. 98–369, § 2350(c), inserted ''and skilled nursing facilities'' after ''hospitals'', inserted ''or the appropriate basis for payment established under this subchapter'' after ''section 1395x(v) of this title)'', and struck out ''hospital'' before ''services furnished to individuals''.

Subsec. (g)(5). Pub. L. 98–369, § 2350(b)(2), added par. (5).

1983—Subsec. (a)(5)(A)(ii). Pub. L. 98–21, § 606(a)(3)(H)(i), substituted ''1395r(a)(1)'' for ''1395r(c)(1)''.

Subsec. (a)(5)(B)(ii). Pub. L. 98–21, § 606(a)(3)(H)(ii), substituted ''1395r(a)(4)'' for ''1395r(c)(4)''.

Subsec. (g)(1). Pub. L. 97–448 substituted ''subsection (b)'' for ''subsection (b)(1)''.

Subsec. (g)(4). Pub. L. 98–21, § 602(g), added par. (4).

1982—Pub. L. 97–248 completely revised section, expanding its coverage to permit payments to both health maintenance organizations and competitive medical plans.

1978—Subsec. (b)(2)(B). Pub. L. 95–292 substituted ''Administrator of the Health Care Financing Administration'' for ''Commissioner of Social Security''.

1976—Subsec. (b). Pub. L. 94–460, § 201(a), struck out provisions defining a health maintenance organization as a public or private organization which provides physicians' services and a sufficient number of primary care and specialty care physicians, assures its members access to qualified practitioners in specialties available in area served by such organization, demonstrates financial responsibility and means to provide comprehensive health care services, has at least half of its enrolled members under age 65, assures prompt and qualified health service, and has an open enrollment period at least every year, and revised the definition and requirements of an health maintenance organization to conform to those set forth in the Public Health Service Act, except that the services which such an organization must provide are those covered in parts A and B of this subchapter rather than the basic health services defined in the Public Health Service Act, and inserted provisions requiring Secretary to administer determinations of whether an organization is a health maintenance organization through and in the office of the Assistant Secretary for Health, to integrate the administration of such functions and duties with the administration of provisions requiring the continued regulation of health maintenance organizations under the Public Health Service Act, and to administer other provisions of this section through the Commissioner of Social Security.

Subsec. (h). Pub. L. 94–460, § 201(b), substituted provisions that each health maintenance organization with which the Secretary enters into a contract under this section have an enrolled membership at least half of which consists of individuals who have not attained age 65, with the Secretary empowered to waive that requirement for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i) of this section for provisions that such requirement not apply with respect to any health maintenance organization for such period not to exceed three years from the date such organization enters into an agreement with the Secretary pursuant to subsection (i) of this section, as the Secretary might permit.

Subsec. (i)(6)(B). Pub. L. 94–460, § 201(c), substituted ''(other than costs with respect to out-of-area services

and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year)'' for ''(Other than those with respect to out-of-area services)''.

Subsec. (k). Pub. L. 94–460, § 201(d), added subsec. (k).

1973—Subsec. (a)(3)(A)(ii). Pub. L. 93–233, § 18(m), struck out '', with the apportionment of savings being proportional to the losses absorbed and not yet offset'' at end.

Subsec. (g)(2). Pub. L. 93–233, § 18(n), substituted ''portion of its premium rate or other charges'' for ''portion'' and ''shall not exceed'' for ''may not exceed'', and struck out cl. (i) designation preceding ''the actuarial value'' and provisions reading ''less (ii) the actuarial value of other charges made in lieu of such deductible and coinsurance'', respectively.

1972—Subsec. (i). Pub. L. 92–603, § 278(b)(3), substituted ''skilled nursing facility'' for ''extended care facility'' and ''skilled nursing facilities'' for ''extended care facilities''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, § 215(c), Aug. 21, 1996, 110 Stat. 2007, provided that: ''The amendments made by this section [amending this section] shall apply with respect to contract years beginning on or after January 1, 1997.''

Amendment by section 231(g) of Pub. L. 104–191 applicable to acts or omissions occurring on or after Jan. 1, 1997, see section 231(i) of Pub. L. 104–191, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 157(b)(8) of Pub. L. 103–432, set out as a note under section 1395y of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4204(a)(4), Nov. 5, 1990, 104 Stat. 1388–109, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by paragraph (3) [amending section 1320a–7a of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, § 4204(c)(3), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, § 157(b)(2), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for years beginning with 1991 with an eligible organization which has entered into a risk-sharing contract under section 1876 of the Social Security Act [42 U.S.C. 1395mm].''

Pub. L. 101–508, title IV, § 4204(d)(2), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, § 157(b)(3), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply with respect to items and services furnished on or after January 1, 1991.''

Pub. L. 101–508, title IV, § 4204(e)(2), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, § 157(b)(5), Oct. 31, 1994, 108 Stat. 4442, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply with respect to individuals enrolling with an eligible organization under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) on or after January 1, 1991.''

Amendment by section 4206(b)(1) of Pub. L. 101–508 applicable to contracts under this section and payments under section 1395*l*(a)(1)(A) of this title as of the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(2) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 1989 AMENDMENTS

Pub. L. 101–239, title VI, § 6206(b)(2), Dec. 19, 1989, 103 Stat. 2245, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect 60 days after the date of the enactment of this Act [Dec. 19, 1989].''

Pub. L. 101–239, title VI, § 6212(b)(2), Dec. 19, 1989, 103 Stat. 2250, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after April 1, 1990.''

Pub. L. 101–239, title VI, § 6212(c)(3), Dec. 19, 1989, 103 Stat. 2250, provided that: ''The amendments made by this subsection [amending this section and repealing provisions set out as notes below] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

Pub. L. 101–239, title VI, § 6411(d)(4)(B), Dec. 19, 1989, 103 Stat. 2271, provided that: ''The amendments made by paragraph (3) [amending this section and section 1396a of this title] shall apply to employment and contracts as of 90 days after the date of the enactment of this Act [Dec. 19, 1989].''

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Amendment by section 202(a) of Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Pub. L. 100–647, title VIII, § 8412(b), Nov. 10, 1988, 102 Stat. 3801, provided that: ''The amendments made by subsection (a) [amending this section] shall not apply to contracts in effect on the date of the enactment of this Act [Nov. 10, 1988] or extensions (not exceeding 90 days) thereof.''

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(f) of Pub. L. 100–360 applicable to enrollments effected on or after Jan. 1, 1990, see section 202(m)(3) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 211(c)(3) of Pub. L. 100–360 applicable, except as specified in such amendment, to monthly premiums for months beginning with January 1989, see section 211(d) of Pub. L. 100–360, set out as a note under section 1395r of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(1), (3), (4), (6), (e)(3) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that

provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4011(a)(2), Dec. 22, 1987, 101 Stat. 1330–60, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, §4011(b)(2), Dec. 22, 1987, 101 Stat. 1330–60, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, §4012(d), Dec. 22, 1987, 101 Stat. 1330–61, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1395cc this title] shall apply to admissions occurring on or after April 1, 1988, or, if later, the earliest date the Secretary can provide the information required under subsection (c) [set out as a note below] in machine readable form.''

Pub. L. 100–203, title IV, §4013(b), Dec. 22, 1987, 101 Stat. 1330–61, which provided the effective date for amendment made by section 4013(a) of Pub. L. 100–203, was omitted in the general amendment of section 4013 of Pub. L. 100–203 by Pub. L. 100–360, title IV, §411(c)(3), July 1, 1988, 102 Stat. 773.

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–514, title XVIII, §1895(b)(11)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to determinations of per capita payment rates for 1987 and subsequent years.''

Pub. L. 99–509, title IX, §9312(b)(2), Oct. 21, 1986, 100 Stat. 1999, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date.''

Pub. L. 99–509, title IX, §9312(c)(3), Oct. 21, 1986, 100 Stat. 2000, as amended by Pub. L. 100–203, title IV, §4018(d), Dec. 22, 1987, 101 Stat. 1330–66; Pub. L. 101–239, title VI, §6212(a), Dec. 19, 1989, 103 Stat. 2249; Pub. L. 103–66, title XIII, §13569, Aug. 10, 1993, 107 Stat. 608, provided that:

''(A) NEW RESTRICTION.—The amendment made by paragraph (1) [amending this section] shall apply to modifications and waivers granted after the date of the enactment of this Act [Oct. 21, 1986].

''(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act.

''(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that—

''(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act [42 U.S.C. 1395mm(f)(2)], a modification or waiver of the requirement imposed by paragraph (1) of that section, but

''(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act [42 U.S.C. 1395mm(f)(3)] (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.

''(D) TREATMENT OF CERTAIN WAIVERS.—In the case of an eligible organization (or successor organization) that is described in clauses (i) and (ii) of subparagraph (C) and that received a grant or grants totaling at least $3,000,000 in fiscal year 1987 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act [42 U.S.C. 254b(d)(1)(A), 254c(d)(1)]—

''(i) before January 1, 1996, section 1876(f) of the Social Security Act [42 U.S.C. 1395mm(f)] shall not apply to the organization;

''(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall conduct an annual review of the organization to determine the organization's compliance with the quality assurance requirements of section 1876(c)(6) of such Act [42 U.S.C. 1395mm(c)(6)]; and

''(iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act [42 U.S.C. 1395mm(f)(3)] effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act.''

Pub. L. 99–509, title IX, §9312(d)(2), Oct. 21, 1986, 100 Stat. 2001, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to risk-sharing contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] with respect to services furnished on or after January 1, 1987.''

Pub. L. 99–509, title IX, §9312(e)(2), Oct. 21, 1986, 100 Stat. 2001, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to contracts as of January 1, 1987.''

Pub. L. 99–509, title IX, §9353(e)(3)(B), Oct. 21, 1986, 100 Stat. 2049, as amended by Pub. L. 100–203, title IV, §4039(h)(9)(C), as added by Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776, provided that: ''The amendment made by paragraph (2) [amending this section] shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act [42 U.S.C. 1395mm], as of April 1, 1987. The provisions of section 1876(i)(7) of the Social Security Act [42 U.S.C. 1395mm(i)(7)] (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97–248 [Sept. 3, 1982]) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act [Dec. 22, 1987]).''

Pub. L. 99–272, title IX, §9211(e), Apr. 7, 1986, 100 Stat. 179, provided that:

''(1) FINANCIAL RESPONSIBILITY.—The amendments made by subsection (a) [amending this section] shall apply to enrollments and disenrollments that become effective on or after the date of the enactment of this Act [Apr. 7, 1986].

''(2) DISENROLLMENTS.—The amendments made by subsection (b) [amending this section] shall apply to requests for termination of enrollment submitted on or after May 1, 1986.

''(3) MATERIAL REVIEW.—(A) The amendment made by subsection (c) [amending this section] shall not apply to material which has been distributed before July 1, 1986.

''(B) Such amendment also shall not apply so as to require the submission of material which is distributed before July 1, 1986.

''(C) Such amendment shall also not apply to material which the Secretary determines has been prepared before the date of the enactment of this Act [Apr. 7, 1986] and for which a commitment for distribution has been made, if the application of such amendment would constitute a hardship for the organization involved.

''(4) PUBLICATION.—The amendment made by subsection (d) [amending this section] shall apply to determinations of per capita rates of payment for 1987 and subsequent years.

''(5) NECESSARY MODIFICATION OF CONTRACTS.—The Secretary of Health and Human Services shall provide for such changes in the risk-sharing contracts which have been entered into under section 1876 of the Social Security Act [42 U.S.C. 1395mm] as may be necessary to conform to the requirements imposed by the amendments made by this section [amending this section] on a timely basis.''

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2350(d), July 18, 1984, 98 Stat. 1098, provided that: ''The amendments made by this section [amending this section and enacting provisions set out as notes under this section] shall become effective on the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(37), (38) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENTS; TRANSITIONAL RULE

Amendment by section 602(g) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by section 606(a)(3)(H) of Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

Amendment by section 309(b)(12) of Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, § 114(c), Sept. 3, 1982, 96 Stat. 350, as amended by Pub. L. 98–369, div. B, title III, § 2354(c)(3)(A), (B), July 18, 1984, 98 Stat. 1102; Pub. L. 98–617, § 3(a)(5), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, § 9312(a), Oct. 21, 1986, 100 Stat. 1999, provided that:

''(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply with respect to services furnished on or after the initial effective date (as defined in paragraph (4)), except that such amendment shall not apply—

''(A) with respect to services furnished by an eligible organization to any individual who is enrolled with that organization under an existing cost contract (as defined in paragraph (3)(A)) and entitled to benefits under part A [42 U.S.C. 1395c et seq.], or enrolled in part B [42 U.S.C. 1395j et seq.], of title XVIII of the Social Security Act at the time the organization first enters into a new risk-sharing contract (as defined in paragraph (3)(D)) unless—

''(i) the individual requests at any time that the amendment apply, or

''(ii) the Secretary determines at any time that the amendment should apply to all members of the organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the eligible organization;

''(B) with respect to services furnished by an eligible organization during the five-year period beginning on the initial effective date, if—

''(i) the organization has an existing risk-sharing contract (as defined in paragraph (3)(B)) on the initial effective date, or

''(ii) on the date of the enactment of this Act [Sept. 3, 1982] the organization was furnishing services pursuant to an existing demonstration project (as defined in paragraph (3)(C)), such demonstration project is concluded before the initial effective date, and before such initial effective date the organization enters into an existing risk-sharing contract,

unless the organization requests that the amendment apply earlier; or

''(C) with respect to services furnished by an eligible organization during the period of an existing demonstration project if on the initial effective date the organization was furnishing services pursuant to the project and if the project concludes after such date.

''(2)(A) In the case of an eligible organization which has in effect an existing cost contract (as defined in paragraph (3)(A)) on the initial effective date, the organization may receive payment under a new risk-sharing contract with respect to a current, nonrisk medicare enrollee (as defined in subparagraph (C)) only to the extent that the organization enrolls, for each such enrollee, two new medicare enrollees (as defined in subparagraph (D)). The selection of those current nonrisk medicare enrollees with respect to whom payment may be so received under a new risk-sharing contract shall be made in a nonbiased manner.

''(B) Subparagraph (A) shall not be construed to prevent an eligible organization from providing for enrollment, on a basis described in subsection (a)(6) of section 1876 of the Social Security Act [42 U.S.C. 1395mm(a)(6)] (as amended by this Act [Pub. L. 97–248], other than under a reasonable cost reimbursement contract), of current, nonrisk medicare enrollees and from providing such enrollees with some or all of the additional benefits described in section 1876(g)(2) of the Social Security Act [42 U.S.C. 1395mm(g)(2)] (as amended by this Act [Pub. L. 97–248]), but (except as provided in subparagraph (A))—

''(i) payment to the organization with respect to such enrollees shall only be made in accordance with the terms of a reasonable cost reimbursement contract, and

''(ii) no payment may be made under section 1876 of such Act [42 U.S.C. 1395mm] with respect to such enrollees for any such additional benefits.

Individuals enrolled with the organization under this subparagraph shall be considered to be individuals enrolled with the organization for the purpose of meeting the requirement of section 1876(g)(2) of the Social Security Act [42 U.S.C. 1395mm(g)(2)] (as amended by this Act [Pub. L. 97–248]).

''(C) For purposes of this paragraph, the term 'current, nonrisk medicare enrollee' means, with respect to an organization, an individual who on the initial effective date—

''(i) is enrolled with that organization under an existing cost contract, and

''(ii) is entitled to benefits under part A [42 U.S.C. 1395c et seq.] and enrolled under part B [42 U.S.C. 1395j et seq.], or enrolled in part B, of title XVIII of the Social Security Act.

''(D) For purposes of this paragraph, the term 'new medicare enrollee' means, with respect to an organization, an individual who—

''(i) is enrolled with the organization after the date the organization first enters into a new risk-sharing contract,

''(ii) at the time of such enrollment is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act, and

''(iii) was not enrolled with the organization at the time the individual became entitled to benefits under part A, or to enroll in part B, of such title.

''(E) The preceding provisions of this paragraph shall not to [sic] apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.

''(3) For purposes of this subsection:

''(A) The term 'existing cost contract' means a contract which is entered into under section 1876 of the Social Security Act [42 U.S.C. 1395mm], as in effect before the initial effective date, or reimbursement on a reasonable cost basis under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395*l*(a)(1)(A)], and which is not an existing risk-sharing contract or an existing demonstration project.

''(B) The term 'existing risk-sharing contract' means a contract entered into under section 1876(i)(2)(A) of the Social Security Act [42 U.S.C. 1395mm(i)(2)(A)], as in effect before the initial effective date.

''(C) The term 'existing demonstration project' means a demonstration project under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)] or under section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92–603, set out as a note under section 1395b–1 of this title], relating to the provision of services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(D) The term 'new risk-sharing contract' means a contract entered into under section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)], as amended by this Act [Pub. L. 97–248].

''(E) The term 'reasonable cost reimbursement contract' means a contract entered into under section 1876(h) of such Act [42 U.S.C. 1395mm(h)], as amended by this Act, or reimbursement on a reasonable cost basis under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395*l*(a)(1)(A)].

''(4) As used in this section, the term 'initial effective date' means—

''(A) the first day of the thirteenth month which begins after the date of the enactment of this Act [Sept. 3, 1982], or

''(B) the first day of the first month [Feb. 1, 1985] after the month in which the Secretary of Health and Human Services notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives that he is reasonably certain that the methodology to make appropriate adjustments (referred to in section 1876(a)(4) of the Social Security Act [42 U.S.C. 1395mm(a)(4)], as amended by this Act [Pub. L. 97–248]) has been developed and can be implemented to assure actuarial equivalence in the estimation of adjusted average per capita costs under that section,

whichever is later.''

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–460, title II, §201(e), Oct. 8, 1976, 90 Stat. 1957, provided that: ''The amendments made by this section [amending this section] shall be effective with respect to contracts entered into between the Secretary and health maintenance organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm] on and after the first day of the first calendar month which begins more than 30 days after the date of enactment of this Act [Oct. 8, 1976].''

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §18(z–3)(3), Dec. 31, 1973, 87 Stat. 974, provided that: ''The amendments made by subsections (m) and (n) [amending this section] shall be effective with respect to services provided after June 30, 1973.''

EFFECTIVE DATE

Pub. L. 92–603, title II, §226(f), Oct. 30, 1972, 86 Stat. 1404, provided that: ''The amendments made by this section [enacting this section, amending sections 1395f, 1395*l*, 1395*ll*, and 1396b of this title, and enacting provisions set out as notes under this section] shall be effective with respect to services provided on or after July 1, 1973.''

REPORT ON IMPACT

Pub. L. 105–33, title IV, §4002(b)(2)(B), Aug. 5, 1997, 111 Stat. 329, provided that: ''By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that analyzes the potential impact of termination of reasonable cost reimbursement contracts, pursuant to the amendment made by subparagraph (A), on medicare beneficiaries enrolled under such contracts and on the medicare program. The report shall include such recommendations regarding any extension or transition with respect to such contracts as the Secretary deems appropriate.''

TRANSITION RULE FOR PSO ENROLLMENT

Pub. L. 105–33, title IV, §4002(h), Aug. 5, 1997, 111 Stat. 330, provided that: ''In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(d)(1) of such Act [42 U.S.C. 1395w–25(d)(1)], as inserted by section 5001 [4001]) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act [42 U.S.C. 1395w–27(b)(1)] (as so inserted).''

REQUIREMENTS WITH RESPECT TO ACTUARIAL EQUIVALENCE OF AAPCC

Pub. L. 101–508, title IV, §4204(b), Nov. 5, 1990, 104 Stat. 1388–109, as amended by Pub. L. 103–432, title I, §157(a), Oct. 31, 1994, 108 Stat. 4441; Pub. L. 104–316, title I, §122(g), Oct. 19, 1996, 110 Stat. 3837, provided that:

''(1)(A) Not later than October 1, 1995, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1997 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)].

''(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

''(i) the difference in costs associated with medicare beneficiaries with differing health status and demographic characteristics; and

''(ii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

''(2) Not later than 3 months after the date of submittal of the proposal under paragraph (1), the Comptroller General shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications.''

[Amendment by section 122(g) of Pub. L. 104–316 to section 4204(b)(4), (5) of Pub. L. 101–508, set out above, could not be executed, because section 4204(b) of Pub. L.

101–508 did not contain pars. (4) and (5) subsequent to amendment by Pub. L. 103–432.]

STUDY OF CHIROPRACTIC SERVICES

Pub. L. 101–508, title IV, § 4204(f), Nov. 5, 1990, 104 Stat. 1388–112, as amended by Pub. L. 103–432, title I, § 157(b)(6), Oct. 31, 1994, 108 Stat. 4442, directed Secretary to conduct a study of the extent to which health maintenance organizations with contracts under section 1876 of the Social Security Act (this section) make available to enrollees entitled to benefits under title XVIII of such Act (this subchapter) chiropractic services that are covered under such title, such study to examine the arrangements under which such services are made available and the types of practitioners furnishing such services to such enrollees and to be based on contracts entered into or renewed on or after Jan. 1, 1991, and before Jan. 1, 1993, with Secretary to issue a report to Congress on results of the study not later than Jan. 1, 1993, including recommendations with respect to any legislative and regulatory changes determined necessary by Secretary to ensure access to such services.

EFFECT ON STATE LAW

Conscientious objections of health care provider under State law unaffected by enactment of subsec. (c)(8) of this section, see section 4206(c) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

NOTICE OF METHODOLOGY USED IN MAKING ANNOUNCEMENTS UNDER SUBSECTION (a)(1)(A)

Pub. L. 101–239, title VI, § 6206(a)(2), Dec. 19, 1989, 103 Stat. 2244, provided that: ''Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act [42 U.S.C. 1395mm(a)(1)(A)] for 1990.''

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

Pub. L. 101–234, title II, § 203(b), Dec. 13, 1989, 103 Stat. 1984, provided that: ''Notwithstanding any other provision of this Act [see Tables for classification], the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act [42 U.S.C. 1395*l*(c)(5), 1395m(c)(6)]) shall not apply to risk-sharing contracts, for contract year 1990—

''(1) with eligible organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm], or

''(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act [42 U.S.C. 1395mm(i)(2)(A)] (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], or under section 222(a) of the Social Security Amendments of 1972 [Pub. L. 92–603, set out as a note under section 1395b–1 of this title].''

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

Pub. L. 100–360, title II, § 222, July 1, 1988, 102 Stat. 746, as amended by Pub. L. 100–485, title VI, § 608(d)(13), Oct. 13, 1988, 102 Stat. 2415, provided that: ''The Secretary of Health and Human Services shall—

''(1) modify contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm], for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act [see Short Title of 1988 Amendment note under section 1305 of this title]; and

''(2) require such organizations and organizations paid under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395*l*(a)(1)(A)] to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act [42 U.S.C. 1395mm(i)(2)(A)] (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], or under section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note], for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act.''

PROVISION OF MEDICARE DRG RATES FOR CERTAIN PAYMENTS AND DATA ON INPATIENT COST PASS-THROUGH ITEMS

Pub. L. 100–203, title IV, § 4012(c), Dec. 22, 1987, 101 Stat. 1330–61, as amended by Pub. L. 100–360, title IV, § 411(c)(2)(B), July 1, 1988, 102 Stat. 773, provided that: ''The Secretary of Health and Human Services shall provide (in machine readable form) to eligible organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm] medicare DRG rates for payments required by the amendment made by subsection (a) [amending section 1395cc of this title] and data on cost pass-through items for all inpatient services provided to medicare beneficiaries enrolled with such organizations.''

MEDICARE PAYMENT DEMONSTRATION PROJECTS

Pub. L. 100–203, title IV, § 4015, Dec. 22, 1987, 101 Stat. 1330–62, as amended by Pub. L. 100–360, title IV, § 411(c)(5), as added by Pub. L. 100–485, title VI, § 608(d)(19)(C), Oct. 13, 1988, 102 Stat. 2419, provided that: ''(a) MEDICARE INSURED GROUP DEMONSTRATION PROJECTS.—

''(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') may provide for capitation demonstration projects (in this subsection referred to as 'projects') with an entity which is an eligible organization with a contract with the Secretary under section 1876 of the Social Security Act [42 U.S.C. 1395mm] or which meets the restrictions and requirements of this subsection. The Secretary may not approve a project unless it meets the requirements of this subsection.

''(2) The Secretary may not conduct more than 3 projects and may not expend, from funds under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], more than $600,000,000 in any fiscal year for all such projects.

''(3) The per capita rate of payment under a project—

''(A) may be based on the adjusted average per capita cost (as defined in section 1876(a)(4) of the Social Security Act [42 U.S.C. 1395mm(a)(4)]) determined only with respect to the group of individuals involved (rather than with respect to medicare beneficiaries generally), but

''(B) the rate of payment may not exceed the lesser of—

''(i) 95 percent of the adjusted average per capita cost described in subparagraph (A), or

''(ii)(I) in the 4th year or 5th year of a project, 115 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) of such Act [42 U.S.C. 1395mm(a)(4)]) for classes of individuals described in section 1876(a)(1)(B) of that Act [42 U.S.C. 1395mm(a)(1)(B)], or

''(II) in any subsequent year of a project, 95 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) [42 U.S.C. 1395mm(a)(4)]) for such classes.

''(4) If the payment amounts made to a project are greater than the costs of the project (as determined by the Secretary or, if applicable, on the basis of adjusted community rates described in section 1876(e)(3) of the Social Security Act [42 U.S.C. 1395mm(e)(3)]), the project—

''(A) may retain the surplus, but not to exceed 5 percent of the average adjusted per capita cost determined in accordance with paragraph (3)(A), and

''(B) with respect to any additional surplus not retained by the project, shall apply such surplus to additional benefits for individuals served by the project or return such surplus to the Secretary.

''(5) Enrollment under the project shall be voluntary. Individuals enrolled with the project may terminate such enrollment as of the beginning of the first calendar month following the date on which the request is made for such termination. Upon such termination, such individuals shall retain the same rights to other health benefits that such individuals would have had if they had never enrolled with the project without any exclusion or waiting period for pre-existing conditions.

''(6) The requirements of—

''(A) subsection (c)(3)(C) (relating to dissemination of information),

''(B) subsection (c)(3)(E) (annual statement of rights),

''(C) subsection (c)(5) (grievance procedures),

''(D) subsection (c)(6) (on-going quality),

''(E) subsection (g)(6) (relating to prompt payment of claims),

''(F) subsection (i)(3)(A) and (B) (relating to access to information and termination notices),

''(G) subsection (i)(6) (relating to providing necessary services), and

''(H) subsection (i)(7) (relating to agreements with peer review [now ''quality improvement''] organizations),

of section 1876 of the Social Security Act [42 U.S.C. 1395mm] shall apply to a project in the same manner as they apply to eligible organizations with risk-sharing contracts under such section.

''(7) The benefits provided under a project must be at least actuarially equivalent to the combination of the benefits available under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the benefits available through any alternative plans in which the individual can enroll through the employer. The project shall guarantee the actuarial value of benefits available under the employer plan for the duration of the project.

''(8) A project shall comply with all applicable State laws.

''(9) The Secretary may not authorize a project unless the entity offering the project demonstrates to the satisfaction of the Secretary that it has the necessary financial reserves to pay for any liability for benefits under the project (including those liabilities for health benefits under medicare and any supplemental benefits).

''(10) The Comptroller General shall monitor projects under this subsection and shall report periodically (not less often than once every year) to the Committee on Finance of the Senate and the Committee on Energy and Commerce and Committee on Ways and Means of the House of Representatives on the status of such projects and the effect on such projects of the requirements of this section and shall submit a final report to each such committee on the results of such projects.

''(b) PAYMENT METHODOLOGY REFORM DEMONSTRATIONS PROJECTS.—

''(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') is specifically authorized to conduct demonstration projects under this subsection for the purpose of testing alternative payment methodologies pertaining to capitation payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], including—

''(A) computing adjustments to the average per capita cost under section 1876 of such Act [42 U.S.C. 1395mm] on the basis of health status or prior utilization of services, and

''(B) accounting for geographic variations in cost in the adjusted average per capita costs applicable to an eligible organization under such section which differs from payments currently provided on a county-by-county basis.

''(2) No project may be conducted under this subsection—

''(A) with an entity which is not an eligible organization (as defined in section 1876(b) of the Social Security Act [42 U.S.C. 1395mm(b)]), and

''(B) unless the project meets all the requirements of subsections (c) and (i)(3) of section 1876 of such Act [42 U.S.C. 1395mm(c), (i)(3)].

''(3) There are authorized to be appropriated to carry out projects under this subsection $5,000,000 in each of fiscal years 1989 and 1990.

''(c) APPLICATION OF PROVISIONS.—The provisions of subsection (a)(2) and the first sentence of subsection (b) of section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)(2), (b)] shall apply to the demonstration projects under this section in the same manner as they apply to experiments under subsection (a)(1) of that section.''

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which the requirement to report not less than once every year to certain committees of Congress under section 4015(a)(10) of Pub. L. 100–203, set out above, is listed on page 9), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

GAO STUDY AND REPORTS ON MEDICARE CAPITATION

Pub. L. 100–203, title IV, § 4017, Dec. 22, 1987, 101 Stat. 1330–64, directed Comptroller General to conduct a study on medicare capitation rates that would include an analysis and assessment of the current method for computing per capita rates of payment under section 1876 of the Social Security Act (this section), including the method for determining the United States per capita cost; the method for establishing relative costs for geographic areas and the data used to establish age, sex, and other weighting factors; ways to refine the calculation of adjusted average per capita costs under section 1876 of such Act, including making adjustments for health status or prior utilization of services and improvements in the definition of geographic areas; the extent to which individuals enrolled with organizations with a risk-sharing contract with the Secretary under section 1876 of such Act differ in utilization and cost from fee-for-service beneficiaries and ways for modifying enrollment patterns through program changes or for reflecting the differences in rates through group experience rating or other means; approaches for limiting the liability of the contracting organization under section 1876 of such Act in catastrophic cases; ways of establishing capitation rates on a basis other than fee-for-service experience in areas with high prepaid market penetration; and methods for providing the rate levels necessary to maintain access to quality prepaid services in rural or medically underserved areas, while maintaining cost savings; and directed Comptroller General, not later than January 1 of 1989 and 1990, to submit to Congress interim reports on the progress of the study and, not later than Jan. 1, 1991, a final report on the results of such study.

DEMONSTRATION PROJECTS TO PROVIDE PAYMENT ON A PREPAID, CAPITATED BASIS FOR COMMUNITY NURSING AND AMBULATORY CARE FURNISHED TO MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 532], Nov. 29, 1999, 113 Stat. 1536, 1501A–388, as amended by Pub. L. 106–554, § 1(a)(6) [title VI, § 632(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that:

''(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–123 [Pub. L. 100–203]; 42 U.S.C. 1395mm note) and conducted for the additional period

of 2 years as provided for under section 4019 of BBA [Pub. L. 105–33, set out as a note below], shall be conducted for an additional period of 2 years.

''(b) TERMS AND CONDITIONS.—

''(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.

''(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

''(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month and furnished during—

''(i) the period beginning with October 1, 2000, and ending with December 31, 2000, shall be determined by actuarially adjusting the actual capitation rate paid for such services in 1999 for inflation, utilization, and other changes to the CNO service package, and by reducing such adjusted capitation rate by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York; and

''(ii) 2001 shall be determined by actuarially adjusting the capitation rate determined under clause (i) for inflation, utilization, and other changes to the CNO service package.

''(B) TARGETED CASE MANAGEMENT FEE.—Effective October 1, 2000—

''(i) the case management fee per enrollee per month for—

''(I) the period described in subparagraph (A)(i) shall be determined by actuarially adjusting the case management fee for 1999 for inflation; and

''(II) 2001 shall be determined by actuarially adjusting the amount determined under subclause (I) for inflation; and

''(ii) such case management fee shall be paid only for enrollees who are classified as moderately frail or frail pursuant to criteria established by the Secretary.

''(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—Each project shall implement for each site—

''(i) protocols for periodic telephonic contact with enrollees based on—

''(I) the results of such standardized written health assessment; and

''(II) the application of appropriate care planning approaches;

''(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

''(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

''(iv) standardized patient educational materials for specified diseases and health conditions.

''(D) QUALITY IMPROVEMENT.—Each project shall implement at each site once during the 15-month period—

''(i) enrollee satisfaction surveys; and

''(ii) reporting on specified quality indicators for the enrolled population.

''(c) EVALUATION.—

''(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways and Means and Commerce [now Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

''(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

''(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

''(2) FINAL REPORT.—The Secretary shall submit a final report to such Committees on such demonstration projects not later than July 1, 2002. Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

''(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending included in such reports shall include a comparison of—

''(A) data for all individuals who—

''(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

''(ii) were enrolled for a minimum of 6 months thereafter; with

''(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and are not enrolled in such a project, or in a Medicare+Choice plan under part C of such title [42 U.S.C. 1395w–21 et seq.], a plan offered by an eligible organization under section 1876 of such Act [42 U.S.C. 1395mm], or a health care prepayment plan under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395*l*(a)(1)(A)].''

[Pub. L. 106–554, § 1(a)(6) [title VI, § 632(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–568, provided that: ''The amendments made by subsection (a) [amending section 1000(a)(6) [title V, § 532] of Pub. L. 106–113, set out above] shall be effective as if included in the enactment of section 532 of BBRA [Pub. L. 106–113, § 1000(a)(6) [title V, § 532] (113 Stat. 1501A–388).'']

Pub. L. 105–33, title IV, § 4019, Aug. 5, 1997, 111 Stat. 347, provided that: ''Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, set out as a note below] may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.''

Pub. L. 100–203, title IV, § 4079, Dec. 22, 1987, 101 Stat. 1330–121, as amended by Pub. L. 100–360, title IV, § 411(h)(8), July 1, 1988, 102 Stat. 787, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into an agreement with not less than four eligible organizations submitting applications under this section to conduct demonstration projects to provide payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to any individual entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] (other than an individual medically determined to have end-stage renal disease) who resides in the geographic area served by the organization and enrolls with such organization (in accordance with subsection (c)(2)).

''(b) DEFINITIONS OF COMMUNITY NURSING AND AMBULATORY CARE AND ELIGIBLE ORGANIZATION.—As used in this section:

''(1) The term 'community nursing and ambulatory care' means the following services:

''(A) Part-time or intermittent nursing care furnished by or under the supervision of registered professional nurses.

''(B) Physical, occupational, or speech therapy.

''(C) Social and related services supportive of a plan of ambulatory care.

''(D) Part-time or intermittent services of a home health aide.

''(E) Medical supplies (other than drugs and biologicals) and durable medical equipment while under a plan of care.

''(F) Medical and other health services described in paragraphs (2)(H)(ii) and (5) through (9) of section 1861(s) of the Social Security Act [42 U.S.C. 1395x(s)(2)(H)(ii), (5)–(9)].

''(G) Rural health clinic services described in section 1861(aa)(1)(C) of such Act [42 U.S.C. 1395x(aa)(1)(C)].

''(H) Certain other related services listed in section 1915(c)(4)(B) of such Act [42 U.S.C. 1396n(c)(4)(B)] to the extent the Secretary finds such services are appropriate to prevent the need for institutionalization of a patient.

''(2) The term 'eligible organization' means a public or private entity, organized under the laws of any State, which meets the following requirements:

''(A) The entity (or a division or part of such entity) is primarily engaged in the direct provision of community nursing and ambulatory care.

''(B) The entity provides directly, or through arrangements with other qualified personnel, the services described in paragraph (1).

''(C) The entity provides that all nursing care (including services of home health aids) is furnished by or under the supervision of a registered nurse.

''(D) The entity provides that all services are furnished by qualified staff and are coordinated by a registered professional nurse.

''(E) The entity has policies governing the furnishing of community nursing and ambulatory care that are developed by registered professional nurses in cooperation with (as appropriate) other professionals.

''(F) The entity maintains clinical records on all patients.

''(G) The entity has protocols and procedures to assure, when appropriate, timely referral to or consultation with other health care providers or professionals.

''(H) The entity complies with applicable State and local laws governing the provision of community nursing and ambulatory care to patients.

''(I) The requirements of subparagraphs (B), (D), and (E) of section 1876(b)(2) of the Social Security Act [42 U.S.C. 1395mm(b)(2)(B), (D), (E)].

''(c) AGREEMENTS WITH ELIGIBLE ORGANIZATIONS TO CONDUCT DEMONSTRATION PROJECTS.—

''(1) The Secretary may not enter into an agreement with an eligible organization to conduct a demonstration project under this section unless the organization meets the requirements of this subsection and subsection (e) with respect to members enrolled with the organization under this section.

''(2) The organization shall have an open enrollment period for the enrollment of individuals under this section. The duration of such period of enrollment and any other requirement pertaining to enrollment or termination of enrollment shall be specified in the agreement with the organization.

''(3) The organization must provide to members enrolled with the organization under this section, through providers and other persons that meet the applicable requirements of titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.], community nursing and ambulatory care (as defined in subsection (b)(1)) which is generally available to individuals residing in the geographic area served by the organization, except that the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered.

''(4) The organization must make community nursing and ambulatory care (and such other health care services as such individuals have contracted for) available and accessible to each individual enrolled with the organization under this section, within the area served by the organization, with reasonable promptness and in a manner which assures continuity.

''(5) Section 1876(c)(5) of the Social Security Act [42 U.S.C. 1395mm(c)(5)] shall apply to organizations under this section in the same manner as it applies to organizations under section 1876 of such Act.

''(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals under the demonstration project conducted under this section, which program (A) stresses health outcomes and (B) provides review by health care professionals of the process followed in the provision of such health care services.

''(7) Under a demonstration project under this section—

''(A) the Secretary could require the organization to provide financial or other assurances (including financial risk-sharing) that minimize the inappropriate substitution of other services under title XVIII of such Act [42 U.S.C. 1395 et seq.] for community nursing services; and

''(B) if the Secretary determines that the organization has failed to perform in accordance with the requirements of the project (including meeting financial responsibility requirements under the project, any pattern of disproportionate or inappropriate institutionalization) the Secretary shall, after notice, terminate the project.

''(d) DETERMINATION OF PER CAPITA PAYMENT RATES.—

''(1) The Secretary shall determine for each 12-month period in which a demonstration project is conducted under this section, and shall announce (in a manner intended to provide notice to interested parties) not later than three months before the beginning of such period, with respect to each eligible organization conducting a demonstration project under this section, a per capita rate of payment for each class of individuals who are enrolled with such organization who are entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

''(2)(A) Except as provided in paragraph (3), the per capita rate of payment under paragraph (1) shall be determined in accordance with this paragraph.

''(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

''(C) The per capita rate of payment under paragraph (1) for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in subparagraph (D)) for that class.

''(D) For purposes of subparagraph (C), the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for those services covered under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] and types of expenses otherwise reimbursable under such parts A and B which are described in subparagraphs (A) through (G) of subsection (b)(1) (including administrative costs incurred by organizations described in sections 1816 and 1842 of such Act [42 U.S.C. 1395h, 1395u]), if the services were to be furnished by other than an eligible organization.

''(3) The Secretary shall, in consultation with providers, health policy experts, and consumer groups develop capitation-based reimbursement rates for such classes of individuals entitled to benefits under part A and enrolled under part B of the Social Secu-

rity Act [probably means parts A and B of title XVIII of that Act, 42 U.S.C. 1395c et seq., 1395j et seq.] as the Secretary shall determine. Such rates shall be applied in determining per capita rates of payment under paragraph (1) with respect to at least one eligible organization conducting a demonstration project under this section.

''(4)(A) In the case of an eligible organization conducting a demonstration project under this section, the Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (2) or (3), except as provided in subsection (e)(3)(B), to the organization for each individual enrolled with the organization.

''(B) The amount of payment under paragraph (2) or (3) may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under such Act [42 U.S.C. 301 et seq.] in such proportions from each such trust fund as the Secretary deems to be fair and equitable taking into consideration benefits attributable to such parts A and B, respectively.

''(6) During any period in which an individual is enrolled with an eligible organization conducting a demonstration project under this section, only the eligible organization (and no other individual or person) shall be entitled to receive payments from the Secretary under this title [probably means title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.] for community nursing and ambulatory care (as defined in subsection (b)(1)) furnished to the individual.

''(e) RESTRICTION ON PREMIUMS, DEDUCTIBLES, COPAYMENTS, AND COINSURANCE.—

''(1) In no case may the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to community nursing and ambulatory care) to individuals who are enrolled under this section with the organization, exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B of the Social Security Act [probably means parts A and B of title XVIII of that Act, 42 U.S.C. 1395c et seq., 1395j et seq.], if they were not members of an eligible organization.

''(2) If the eligible organization provides to its members enrolled under this section services in addition to community nursing and ambulatory care, election of coverage for such additional services shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

''(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

''(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services (as defined in section 1876(e)(3) of the Social Security Act [42 U.S.C. 1395mm(e)(3)]).

''(3)(A) Subject to subparagraphs (B) and (C), each agreement to conduct a demonstration project under this section shall provide that if—

''(i) the adjusted community rate, referred to in paragraph (2), for community nursing and ambulatory care covered under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization,

is less than

''(ii) the average of the per capita rates of payment to be made under subsection (d)(1) at the beginning of the 12-month period (as determined on such basis as the Secretary determines appropriate) described in such subsection for members enrolled under this section with the organization,

the eligible organization shall provide to such members the additional benefits described in section 1876(g)(3) of the Social Security Act [42 U.S.C. 1395mm(g)(3)] which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced).

''(B) Subparagraph (A) shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced).

''(C) An organization conducting a demonstration project under this section may provide (with the approval of the Secretary) that a part of the value of such additional benefits under subparagraph (A) be withheld and reserved by the Secretary as provided in section 1876(g)(5) of the Social Security Act [42 U.S.C. 1395mm(g)(5)].

''(4) The provisions of paragraphs (3), (5), and (6) of section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)(3), (5), (6)] shall apply in the same manner to agreements under this section as they apply to risk-sharing contracts under section 1876 of such Act, and, for this purpose, any reference in such paragraphs to paragraph (2) is deemed a reference to paragraph (3) of this subsection.

''(5) Section 1876(e)(4) of the Social Security Act [42 U.S.C. 1395mm(e)(4)] shall apply to eligible organizations under this section in the same manner as it applies to eligible organizations under section 1876 of such Act.

''(f) COMMENCEMENT AND DURATION OF PROJECTS.—Each demonstration project under this section shall begin not later than July 1, 1989, and shall be conducted for a period of three years.

''(g) REPORT.—Not later than January 1, 1992, the Secretary shall submit to the Congress a report on the results of the demonstration projects conducted under this section.''

STUDY OF AAPCC AND ACR

Pub. L. 99–509, title IX, § 9312(g), Oct. 21, 1986, 100 Stat. 2001, directed Secretary of Health and Human Services to provide, through contract with an appropriate organization, for a study of the methods by which the adjusted average per capita cost (''AAPCC'', as defined in subsec. (a)(4) of this section) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and the adjusted community rate (''ACR'', as defined in subsec. (e)(3) of this section) can be refined, with Secretary to submit to Congress, by not later than Jan. 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR could be refined.

ALLOWING MEDICARE BENEFICIARIES TO DISENROLL AT LOCAL SOCIAL SECURITY OFFICES

Pub. L. 99–509, title IX, § 9312(h), Oct. 21, 1986, 100 Stat. 2002, provided that: ''The Secretary of Health and Human Services shall provide that individuals enrolled with an eligible organization under section 1876 of the Social Security Act [42 U.S.C. 1395mm] may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration.''

USE OF RESERVE FUNDS

Pub. L. 99–509, title IX, § 9312(i), Oct. 21, 1986, 100 Stat. 2002, provided that: ''Notwithstanding any provision of section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) to the contrary, funds reserved by an eligible organization under such section before the date of the enactment of this Act [Oct. 21, 1986] may be applied, at the organization's option, to offset the amount of any reduction in payment amounts to the organization effected under Public Law 99–177 [Dec. 12, 1985, 99 Stat. 1037, see Tables for classification] during fiscal year 1986.''

PHASE-IN OF ENROLLMENT PERIOD BY SECRETARY

Pub. L. 98–369, div. B, title III, § 2350(a)(2), July 18, 1984, 98 Stat. 1098, provided that: ''The Secretary of Health and Human Services may phase in, over a period of not longer than three years, the application of the amendments made by paragraph (1) [amending this section] to all applicable areas in the United States if the Secretary determines that it is not administratively feasible to establish a single 30-day open enrollment period for all such applicable areas before the end of the period.''

STABILIZATION FUND; ESTABLISHMENT LIMITATION; USES; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, § 2350(b)(3), (4), July 18, 1984, 98 Stat. 1098, as amended by Pub. L. 100–203, title IV, § 4013, Dec. 22, 1987, 101 Stat. 1330–61; Pub. L. 100–360, title IV, § 411(c)(3), July 1, 1988, 102 Stat. 773, prohibited Secretary of Health and Human Services from approving the establishment of a stabilization fund by an eligible organization under subsec. (g)(5) of this section for any contract period beginning later than Sept. 30, 1990, and directed Secretary to report to Congress with respect to use of stabilization funds by eligible organizations under subsec. (g)(5) of this section and to assess the need for such funds not later than 54 months after July 1984, prior to repeal by Pub. L. 101–239, title VI, § 6212(c)(1), Dec. 19, 1989, 103 Stat. 2250.

STUDY OF ADDITIONAL BENEFITS SELECTED BY ELIGIBLE ORGANIZATIONS

Pub. L. 97–248, title I, § 114(d), Sept. 3, 1982, 96 Stat. 352, directed Secretary of Health and Human Services to conduct a study of the additional benefits selected by eligible organizations pursuant to subsec. (g)(2) of this section, with Secretary to report to Congress within 24 months of the initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248) with respect to the findings and conclusions made as a result of such study.

STUDY EVALUATING THE EXTENT OF, AND REASONS FOR, TERMINATION BY MEDICARE BENEFICIARIES OF MEMBERSHIP IN ORGANIZATIONS WITH CONTRACTS UNDER THIS SECTION

Pub. L. 97–248, title I, § 114(e), Sept. 3, 1982, 96 Stat. 352, directed Secretary of Health and Human Services to conduct a study evaluating the extent of, and reasons for, the termination by medicare beneficiaries of their memberships in organizations with contracts under section 1876 of the Social Security Act (this section), with Secretary to submit an interim report to Congress, within two years after the initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248), and a final report within five years after such date containing the respective interim and final findings and conclusions made as a result of such study.

REIMBURSEMENT FOR SERVICES

Pub. L. 92–603, title II, § 226(b), Oct. 30, 1972, 86 Stat. 1403, provided that:

''(1) Notwithstanding the provisions of section 1814 and section 1833 of the Social Security Act [42 U.S.C. 1395f, 1395*l*], any health maintenance organization which has entered into a contract with the Secretary pursuant to section 1876 of such Act [42 U.S.C. 1395mm] shall, for the duration of such contract, (except as provided in paragraph (2)) be entitled to reimbursement only as provided in section 1876 of such Act [42 U.S.C. 1395mm] for individuals who are members of such organizations.

''(2) With respect to individuals who are members of organizations which have entered into a risk-sharing contract with the Secretary pursuant to subsection (i)(2)(A) [of this section] prior to July 1, 1973, and who, although eligible to have payment made pursuant to section 1876 of such Act [42 U.S.C. 1395mm] for services rendered to them, chose (in accordance with regulations) not to have such payment made pursuant to such section, the Secretary shall, for a period not to exceed three years commencing on July 1, 1973, pay to such organization on the basis of an interim per capita rate, determined in accordance with the provisions of section 1876(a)(2) of such Act [42 U.S.C. 1395mm(a)(2)], with appropriate actuarial adjustments to reflect the difference in utilization of out-of-plan services, which would have been considered sufficiently reasonable and necessary under the rules of the health maintenance organization to be provided by that organization, between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act [42 U.S.C. 1395mm]. Payments under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

''(3) If the Secretary determines that the per capita cost of any such organization in any contract year for providing services to individuals described in paragraph (2), when combined with the cost of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such year for providing out-of-plan services to such individuals, is less than or greater than the adjusted average per capita cost (as defined in section 1876(a)(3) of such Act [42 U.S.C. 1395mm(a)(3)]) of providing such services, the resulting savings shall be apportioned between such organization and such Trust Funds, or the resulting losses shall be absorbed by such organization, in the manner prescribed in section 1876(a)(3) of such Act [42 U.S.C. 1395mm(a)(3)].''

§ 1395nn. Limitation on certain physician referrals

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b), if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity, or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions

Subsection (a)(1) shall not apply in the following cases:

(1) Physicians' services

In the case of physicians' services (as defined in section 1395x(q) of this title) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

(2) In-office ancillary services

In the case of services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)—

(A) that are furnished—

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice—

(aa) for the provision of some or all of the group's clinical laboratory services, or

(bb) for the centralized provision of the group's designated health services (other than clinical laboratory services),

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse. Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1395x(d) of this title) who furnish such services in the area in which such individual resides.

(3) Prepaid plans

In the case of services furnished by an organization—

(A) with a contract under section 1395mm of this title to an individual enrolled with the organization,

(B) described in section 1395*l*(a)(1)(A) of this title to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under section 1395b–1(a) of this title or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization,

(D) that is a qualified health maintenance organization (within the meaning of section 300e–9(d)[1] of this title) to an individual enrolled with the organization, or

(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1395w–21(a)(2)(A) of this title to an individual enrolled with the organization.

(4) Other permissible exceptions

In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5) Electronic prescribing

An exception established by regulation under section 1395w–104(e)(6) of this title.[1]

(c) General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds

Ownership of the following shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which may be purchased on terms generally available to the public and which are—

[1] See References in Text note below.

(A)(i) securities listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis, or

(ii) traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

(B) in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous 3 fiscal years, stockholder equity exceeding $75,000,000.

(2) Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if such company had, at the end of the company's most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75,000,000.

(d) Additional exceptions related only to ownership or investment prohibition

The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Hospitals in Puerto Rico

In the case of designated health services provided by a hospital located in Puerto Rico.

(2) Rural providers

In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

(B) effective for the 18-month period beginning on December 8, 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)); and

(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).

(3) Hospital ownership

In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services at the hospital;

(B) effective for the 18-month period beginning on December 8, 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7));

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital); and

(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after March 23, 2010.

(e) Exceptions relating to other compensation arrangements

The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

(1) Rental of office space; rental of equipment

(A) Office space

Payments made by a lessee to a lessor for the use of premises if—

(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee's pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Equipment

Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee,

(iii) the lease provides for a term of rental or lease of at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(C) Holdover lease arrangements

In the case of a holdover lease arrangement for the lease of office space or equip-

ment, which immediately follows a lease arrangement described in subparagraph (A) for the use of such office space or subparagraph (B) for the use of such equipment and that expired after a term of at least 1 year, payments made by the lessee to the lessor pursuant to such holdover lease arrangement, if—

(i) the lease arrangement met the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment when the arrangement expired;

(ii) the holdover lease arrangement is on the same terms and conditions as the immediately preceding arrangement; and

(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment.

(2) Bona fide employment relationships

Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—

(A) the employment is for identifiable services,

(B) the amount of the remuneration under the employment—

(i) is consistent with the fair market value of the services, and

(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,

(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

(3) Personal service arrangements

(A) In general

Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if—

(i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,

(ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,

(iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,

(iv) the term of the arrangement is for at least 1 year,

(v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and

(vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Physician incentive plan exception

(i) In general

In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1395mm(i)(8)(A)(ii) of this title, the plan complies with any requirements the Secretary may impose pursuant to such section.

(III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

(ii) "Physician incentive plan" defined

For purposes of this subparagraph, the term ''physician incentive plan'' means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(C) Holdover personal service arrangement

In the case of a holdover personal service arrangement, which immediately follows an arrangement described in subparagraph (A) that expired after a term of at least 1 year, remuneration from an entity pursuant to such holdover personal service arrangement, if—

(i) the personal service arrangement met the conditions of subparagraph (A) when the arrangement expired;

(ii) the holdover personal service arrangement is on the same terms and conditions as the immediately preceding arrangement; and

(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A).

(4) Remuneration unrelated to the provision of designated health services

In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

(5) Physician recruitment

In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

(A) the physician is not required to refer patients to the hospital,

(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) Isolated transactions

In the case of an isolated financial transaction, such as a one-time sale of property or practice, if—

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(7) Certain group practice arrangements with a hospital

(A)[2] In general

An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if—

(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1395x(b)(3) of this title,

(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the services to be provided by the parties and the compensation for services provided under the agreement,

(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(8) Payments by a physician for items and services

Payments made by a physician—

(A) to a laboratory in exchange for the provision of clinical laboratory services, or

(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

(f) Reporting requirements

Each entity providing covered items or services for which payment may be made under this subchapter shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides[3] services for which payment may be made under this subchapter very infrequently.

(g) Sanctions

(1) Denial of payment

No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1).

(2) Requiring refunds for certain claims

If a person collects any amounts that were billed in violation of subsection (a)(1), the per-

[2] So in original. No subpar. (B) has been enacted.

[3] So in original. Probably should be ''provide''.

son shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims

Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) Civil money penalty and exclusion for circumvention schemes

Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(5) Failure to report information

Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Advisory opinions

(A) In general

The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Application of certain rules

The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) and take into account the regulations promulgated under subsection (b)(5) of section 1320a–7d of this title in the issuance of advisory opinions under this paragraph.

(C) Regulations

In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(D) Applicability

This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after August 5, 1997, and before the close of the period described in section 1320a–7d(b)(6) of this title.

(h) Definitions and special rules

For purposes of this section:

(1) Compensation arrangement; remuneration

(A) The term ''compensation arrangement'' means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than an arrangement involving only remuneration described in subparagraph (C).

(B) The term ''remuneration'' includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(ii) The provision of items, devices, or supplies that are used solely to—

(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

(II) order or communicate the results of tests or procedures for such entity.

(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

(I) the health services are not furnished, and the payment is not made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

(II) the payment is made to the physician on behalf of the covered individual and would otherwise be made directly to such individual,

(III) the amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals, and

(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(D) WRITTEN REQUIREMENT CLARIFIED.—In the case of any requirement pursuant to this sec-

tion for a compensation arrangement to be in writing, such requirement shall be satisfied by such means as determined by the Secretary, including by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties involved.

(E) SPECIAL RULE FOR SIGNATURE REQUIREMENTS.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing and signed by the parties, such signature requirement shall be met if—

(i) not later than 90 consecutive calendar days immediately following the date on which the compensation arrangement became noncompliant, the parties obtain the required signatures; and

(ii) the compensation arrangement otherwise complies with all criteria of the applicable exception.

(2) Employee

An individual is considered to be ''employed by'' or an ''employee'' of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

(3) Fair market value

The term ''fair market value'' means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) Group practice

(A) Definition of group practice

The term ''group practice'' means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(i) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel,

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group,

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) Special rules

(i) Profits and productivity bonuses

A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

(ii) Faculty practice plans

In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(5) Referral; referring physician

(A) Physicians' services

Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a ''referral'' by a ''referring physician''.

(B) Other items

Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the designated health service constitutes a ''referral'' by a ''referring physician''.

(C) Clarification respecting certain services integral to a consultation by certain specialists

A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a ''referral'' by a ''referring physician''.

(6) Designated health services

The term ''designated health services'' means any of the following items or services:

(A) Clinical laboratory services.

(B) Physical therapy services.

(C) Occupational therapy services.

(D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services.

(E) Radiation therapy services and supplies.

(F) Durable medical equipment and supplies.

(G) Parenteral and enteral nutrients, equipment, and supplies.

(H) Prosthetics, orthotics, and prosthetic devices and supplies.

(I) Home health services.

(J) Outpatient prescription drugs.

(K) Inpatient and outpatient hospital services.

(L) Outpatient speech-language pathology services.

(7) Specialty hospital

(A) In general

For purposes of this section, except as provided in subparagraph (B), the term ''specialty hospital'' means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

(i) Patients with a cardiac condition.

(ii) Patients with an orthopedic condition.

(iii) Patients receiving a surgical procedure.

(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

(B) Exception

For purposes of this section, the term ''specialty hospital'' does not include any hospital—

(i) determined by the Secretary—

(I) to be in operation before November 18, 2003; or

(II) under development as of such date;

(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

(v) that meets such other requirements as the Secretary may specify.

(i) Requirements for hospitals to qualify for rural provider and hospital exception to ownership or investment prohibition

(1) Requirements described

For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) Provider agreement

The hospital had—

(i) physician ownership or investment on December 31, 2010; and

(ii) a provider agreement under section 1395cc of this title in effect on such date.

(B) Limitation on expansion of facility capacity

Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

(C) Preventing conflicts of interest

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment interests in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

(II) if applicable, any such ownership or investment interest of the treating physician.

(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

(I) on any public website for the hospital; and

(II) in any public advertising for the hospital.

(D) Ensuring bona fide investment

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

(ii) Any ownership or investment interests that the hospital offers to a physician owner

or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(E) Patient safety

(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

(I) the hospital discloses such fact to a patient; and

(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

(ii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(F) Limitation on application to certain converted facilities

The hospital was not converted from an ambulatory surgical center to a hospital on or after March 23, 2010.

(2) Publication of information reported

The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

(3) Exception to prohibition on expansion of facility capacity

(A) Process

(i) Establishment

The Secretary shall establish and implement a process under which a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described in subparagraph (F) may apply for an exception from the requirement under paragraph (1)(B).

(ii) Opportunity for community input

The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) Timing for implementation

The Secretary shall implement the process under clause (i) on February 1, 2012.

(iv) Regulations

Not later than January 1, 2012, the Secretary shall promulgate regulations to carry out the process under clause (i).

(B) Frequency

The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(C) Permitted increase

(i) In general

Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

(ii) 100 percent increase limitation

The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(iii) Baseline number of operating rooms, procedure rooms, and beds

In this paragraph, the term ''baseline number of operating rooms, procedure rooms, and beds'' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is li-

censed as of March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement).

(D) Increase limited to facilities on the main campus of the hospital

Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(E) Applicable hospital

In this paragraph, the term ''applicable hospital'' means a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under subchapter XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

(F) High Medicaid facility described

A high Medicaid facility described in this subparagraph is a hospital that—

(i) is not the sole hospital in a county;

(ii) with respect to each of the 3 most recent years for which data are available, has an annual percent of total inpatient admissions that represent inpatient admissions under subchapter XIX that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and

(iii) meets the conditions described in subparagraph (E)(iii).

(G) Procedure rooms

In this subsection, the term ''procedure rooms'' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(H) Publication of final decisions

Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

(I) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the process under this paragraph (including the establishment of such process).

(4) Collection of ownership and investment information

For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

(5) Physician owner or investor defined

For purposes of this subsection, the term ''physician owner or investor'' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

(6) Clarification

Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1395cc of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1877, as added Pub. L. 101–239, title VI, § 6204(a), Dec. 19, 1989, 103 Stat. 2236; amended Pub. L. 101–508, title IV, § 4207(e)(1)–(3), (k)(2), formerly § 4027(e)(1)–(3), (k)(2), Nov. 5, 1990, 104 Stat. 1388–121, 1388–122, 1388–124, renumbered Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 103–66, title XIII, § 13562(a), Aug. 10, 1993, 107 Stat. 596; Pub. L. 103–432, title I, § 152(a), (b), Oct. 31, 1994, 108 Stat. 4436; Pub. L. 105–33, title IV, § 4314, Aug. 5, 1997, 111 Stat. 389; Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 524(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–387; Pub. L. 108–173, title I, § 101(e)(8)(B), title V, § 507(a), Dec. 8, 2003, 117 Stat. 2152, 2295; Pub. L. 110–275, title I, § 143(b)(9), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title VI, §§ 6001(a), 6003(a), title X, § 10601(a), Mar. 23, 2010, 124 Stat. 684, 697, 1005; Pub. L. 111–152, title I, § 1106, Mar. 30, 2010, 124 Stat. 1049; Pub. L. 115–123, div. E, title IV, § 50404, Feb. 9, 2018, 132 Stat. 218.)

Editorial Notes

REFERENCES IN TEXT

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b)(3)(C), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

Section 300e–9(d) of this title, referred to in subsec. (b)(3)(D), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, § 7(b), Oct. 24, 1988, 102 Stat. 2580.

Section 1395w–104(e)(6) of this title, referred to in subsec. (b)(5), was in the original ''section 1860D–3(e)(6)'', and was translated as reading ''section 1860D–4(e)(6)'', meaning section 1860D–4(e)(6) of the Social Security

Act, to reflect the probable intent of Congress, because section 1860D–3, which is classified to section 1395w–103 of this title, does not contain a subsec. (e), and section 1860D–4(e)(6) relates to electronic prescription program regulations.

The Internal Revenue Code, referred to in subsecs. (c)(2) and (h)(2), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1395nn, act Aug. 14, 1935, ch. 531, title XVIII, §1877, as added and amended Oct. 30, 1972, Pub. L. 92–603, title II, §§242(b), 278(b)(8), 86 Stat. 1419, 1454; Oct. 25, 1977, Pub. L. 95–142, §4(a), 91 Stat. 1179; Dec. 5, 1980, Pub. L. 96–499, title IX, §917, 94 Stat. 2625; July 18, 1984, Pub. L. 98–369, div. B, title III, §2306(f)(2), 98 Stat. 1073; Oct. 21, 1986, Pub. L. 99–509, title IX, §9321(a)(1), 100 Stat. 2016; Aug. 18, 1987, Pub. L. 100–93, §4(c), 101 Stat. 689, enumerated offenses relating to the Medicare program and penalties for such offenses, prior to repeal by Pub. L. 100–93, §§4(e), 15(a), Aug. 18, 1987, 101 Stat. 689, 698, effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period.

AMENDMENTS

2018—Subsec. (e)(1)(C). Pub. L. 115–123, §50404(b)(1), added subpar. (C).

Subsec. (e)(3)(C). Pub. L. 115–123, §50404(b)(2), added subpar. (C).

Subsec. (h)(1)(D). Pub. L. 115–123, §50404(a)(1), added subpar. (D).

Subsec. (h)(1)(E). Pub. L. 115–123, §50404(a)(2), added subpar. (E).

2010—Subsec. (b)(2). Pub. L. 111–148, §6003(a), inserted at end of concluding provisions ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1395x(d) of this title) who furnish such services in the area in which such individual resides.''

Subsec. (d)(2)(C). Pub. L. 111–148, §6001(a)(1), added subpar. (C).

Subsec. (d)(3)(D). Pub. L. 111–148, §6001(a)(2), added subpar. (D).

Subsec. (i). Pub. L. 111–148, §6001(a)(3), added subsec. (i).

Subsec. (i)(1)(A)(i). Pub. L. 111–152, §1106(1), substituted ''December 31, 2010'' for ''August 1, 2010''.

Pub. L. 111–148, §10601(a)(1), substituted ''August 1, 2010'' for ''February 1, 2010''.

Subsec. (i)(3)(A)(i). Pub. L. 111–152, §1106(2)(A), substituted ''a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described in subparagraph (F)'' for ''an applicable hospital (as defined in subparagraph (E))''.

Subsec. (i)(3)(A)(iii). Pub. L. 111–148, §10601(a)(2)(A), substituted ''February 1, 2012'' for ''August 1, 2011''.

Subsec. (i)(3)(A)(iv). Pub. L. 111–148, §10601(a)(2)(B), substituted ''January 1, 2012'' for ''July 1, 2011''.

Subsec. (i)(3)(C)(iii). Pub. L. 111–152, §1106(2)(B), inserted ''(or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement)'' after ''March 23, 2010''.

Subsec. (i)(3)(F) to (I). Pub. L. 111–152, §1106(2)(C), (D), added subpar. (F) and redesignated former subpars. (F) to (H) as (G) to (I), respectively.

2008—Subsec. (h)(6)(L). Pub. L. 110–275 added subpar. (L).

2003—Subsec. (b)(5). Pub. L. 108–173, §101(e)(8)(B), added par. (5).

Subsec. (d)(2). Pub. L. 108–173, §507(a)(2), amended heading and text of par. (2) generally. Prior to amendment, text read as follows: ''In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area.''

Subsec. (d)(3)(B), (C). Pub. L. 108–173, §507(a)(1)(A), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (h)(7). Pub. L. 108–173, §507(a)(1)(B), added par. (7).

1999—Subsec. (b)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(1)], struck out ''or'' at the end.

Subsec. (b)(3)(D). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(2)], substituted '', or'' for period at end.

Subsec. (b)(3)(E). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(3)], which directed addition of provisions at end of par. (3) but which separated directory language from language to be added because of the apparent placement out of sequence of pars. (2) and (3) of §524(a), was executed by adding subpar. (E) at end of par. (3) to reflect the probable intent of Congress.

1997—Subsec. (g)(6). Pub. L. 105–33 added par. (6).

1994—Subsec. (f). Pub. L. 103–432, §152(a)(1), (4), (5), in introductory provisions, substituted ''ownership, investment, and compensation arrangements'' for ''ownership arrangements'', and in closing provisions, substituted ''designated health services'' for ''covered items and services'' and struck out ''Such information shall first be provided not later than October 1, 1991.'' after ''shall specify.'' and ''The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44 with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing designated health services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type.'' at end.

Subsec. (f)(2). Pub. L. 103–432, §152(a)(2), (3), inserted '', or with a compensation arrangement (as described in subsection (a)(2)(B)),'' after ''investment interest (as described in subsection (a)(2)(A))'' and ''interest or who have such a compensation relationship with the entity'' before period at end.

Subsec. (h)(6). Pub. L. 103–432, §152(b), in subpar. (D), substituted ''services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services'' for ''or other diagnostic services'', and in subpars. (E), (F), and (H), inserted ''and supplies'' before period at end.

1993—Subsecs. (a) to (e). Pub. L. 103–66, §13562(a)(1), amended headings and text of subsecs. (a) to (e) generally, substituting present provisions for provisions which related to: prohibition of certain referrals in subsec. (a), general exceptions to both ownership and compensation arrangement prohibitions in subsec. (b), general exception related only to ownership or investment prohibition for ownership in publicly-traded securities in subsec. (c), additional exceptions related only to ownership or investment prohibition in subsec. (d), and exceptions relating to other compensation arrangements in subsec. (e).

Subsec. (f). Pub. L. 103–66, §13562(a)(3), substituted ''designated health services'' for ''clinical laboratory services'' in concluding provisions.

Subsec. (g)(1). Pub. L. 103–66, §13562(a)(4), substituted ''designated health service'' for ''clinical laboratory service''.

Subsec. (h). Pub. L. 103–66, §13562(a)(2), amended heading and text of subsec. (h) generally, substituting pars.

(1) to (6) for former pars. (1) to (7) which defined ''compensation arrangement'', ''remuneration'', ''employee'', ''fair market value'', ''group practice'', ''investor'', ''interested investor'', ''disinterested investor'', ''referral'', and ''referring physician''.

1990—Subsec. (b)(4), (5). Pub. L. 101–508, § 4207(e)(2), formerly § 4027(e)(2), as renumbered by Pub. L. 103–432, § 160(d)(4), added par. (4) and redesignated former par. (4) as (5).

Subsec. (f). Pub. L. 101–508, § 4207(e)(3)(B), (C), formerly § 4027(e)(3)(B), (C), as renumbered by Pub. L. 103–432, § 160(d)(4), substituted ''October 1, 1991'' for ''1 year after December 19, 1989'' in third sentence and inserted at end ''The requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this subchapter very infrequently. The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44 with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type.''

Subsec. (f)(2). Pub. L. 101–508, § 4207(e)(3)(A), formerly § 4027(e)(3)(A), as renumbered by Pub. L. 103–432, § 160(d)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors.''

Subsec. (g)(5). Pub. L. 101–508, § 4207(k)(2), formerly § 4027(k)(2), as renumbered by Pub. L. 103–432, § 160(d)(4), inserted at end ''The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Subsec. (h)(6). Pub. L. 101–508, § 4207(e)(1)(C), formerly § 4027(e)(1)(C), as renumbered by Pub. L. 103–432, § 160(d)(4), added par. (6). Former par. (6) redesignated (7).

Pub. L. 101–508, § 4207(e)(1)(A), (B), formerly § 4027(e)(1)(A), (B), as renumbered by Pub. L. 103–432, § 160(d)(4), substituted ''in the case of an item or service for which payment may be made under part B of this subchapter, the request by a physician for the item or service,'' for ''in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service,'' in subpar. (A) and struck out ''in the case of another clinical laboratory service,'' after ''subparagraph (C),'' in subpar. (B).

Subsec. (h)(7). Pub. L. 101–508, § 4207(e)(1)(C), formerly § 4027(e)(1)(C), as renumbered by Pub. L. 103–432, § 160(d)(4), redesignated par. (6) as (7).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, § 6003(b), Mar. 23, 2010, 124 Stat. 697, provided that: ''The amendment made by this section [amending this section] shall apply to services furnished on or after January 1, 2010.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 524(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–388, provided that: ''The amendment made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 29, 1999].''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, § 152(d)(1), Oct. 31, 1994, 108 Stat. 4437, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall apply to referrals made on or after January 1, 1995.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13562(b), Aug. 10, 1993, 107 Stat. 604, as amended by Pub. L. 103–432, title I, § 152(c), Oct. 31, 1994, 108 Stat. 4437, provided that:

''(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to referrals—

''(A) made on or after January 1, 1992, in the case of clinical laboratory services, and

''(B) made after December 31, 1994, in the case of other designated health services.

''(2) EXCEPTIONS.—With respect to referrals made for clinical laboratory services on or before December 31, 1994—

''(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act [42 U.S.C. 1395nn(a)(2), (b)(2)(B), (d)(2)] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

''(B) section 1877(b)(4) of the Social Security Act [42 U.S.C. 1395nn(b)(4)] (as in effect on the day before the date of the enactment of this Act) shall apply;

''(C) the requirements of section 1877(c)(2) of the Social Security Act [42 U.S.C. 1395nn(c)(2)] (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

''(D) section 1877(e)(3) of the Social Security Act [42 U.S.C. 1395nn(e)(3)] (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

''(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act [42 U.S.C. 1395nn(h)(4)(A)(iv), (v), (B)(i)] (as amended by this Act) shall not apply; and

''(F) section 1877(h)(4)(B) of the Social Security Act [42 U.S.C. 1395nn(h)(4)(B)] (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).''

[Pub. L. 103–432, title I, § 152(d)(2), Oct. 31, 1994, 108 Stat. 4437, provided that: ''The amendment made by subsection (c) [amending section 13562(b) of Pub. L. 103–66, set out above] shall apply as if included in the enactment of OBRA–1993 [Pub. L. 103–66].'']

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4207(e)(5), formerly § 4027(e)(5), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994,

108 Stat. 4444, provided that: ''The amendments made by this subsection [amending this section and provisions set out below] shall be effective as if included in the enactment of section 6204 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

EFFECTIVE DATE

Pub. L. 101–239, title VI, § 6204(c), Dec. 19, 1989, 103 Stat. 2242, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1395*l* of this title] shall become effective with respect to referrals made on or after January 1, 1992.

''(2) The reporting requirement of section 1877(f) of the Social Security Act [42 U.S.C. 1395nn(f)] shall take effect on October 1, 1990.''

DEADLINE FOR CERTAIN REGULATIONS

Pub. L. 101–239, title VI, § 6204(d), Dec. 19, 1989, 103 Stat. 2242, as amended by Pub. L. 101–508, title IV, § 4207(e)(4)(B), formerly § 4027(e)(4)(B), Nov. 5, 1990, 104 Stat. 1388–122, renumbered Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act [42 U.S.C. 1395nn] by not later than October 1, 1991.''

ENFORCEMENT

Pub. L. 111–148, title VI, § 6001(b), Mar. 23, 2010, 124 Stat. 689, as amended by Pub. L. 111–148, title X, § 10601(b), Mar. 23, 2010, 124 Stat. 1005, provided that:

''(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act [42 U.S.C. 1395nn(i)(1)], as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

''(2) AUDITS.—Beginning not later than May 1, 2012, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).''

MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL

Pub. L. 111–148, title VI, § 6409, Mar. 23, 2010, 124 Stat. 772, provided that:

''(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

''(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act [Mar. 23, 2010], a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an 'SRDP'). The SRDP shall include direction to health care providers of services and suppliers on—

''(A) a specific person, official, or office to whom such disclosures shall be made; and

''(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

''(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

''(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act [42 U.S.C. 1395nn(g)].

''(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act [42 U.S.C. 1395nn] to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

''(1) The nature and extent of the improper or illegal practice.

''(2) The timeliness of such self-disclosure.

''(3) The cooperation in providing additional information related to the disclosure.

''(4) Such other factors as the Secretary considers appropriate.

''(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

''(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

''(2) the amounts collected pursuant to the SRDP;

''(3) the types of violations reported under the SRDP; and

''(4) such other information as may be necessary to evaluate the impact of this section.''

APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT

Pub. L. 108–173, title V, § 507(b), Dec. 8, 2003, 117 Stat. 2296, provided that: ''For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act [42 U.S.C. 1395nn(h)(7)(B)(i)(II)], as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary [of Health and Human Services] shall consider—

''(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

''(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.''

STUDIES

Pub. L. 108–173, title V, § 507(c), Dec. 8, 2003, 117 Stat. 2296, provided that:

''(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

''(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

''(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

''(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

''(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

''(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

''(2) HHS STUDY.—The Secretary [of Health and Human Services] shall conduct a study of a representative sample of specialty hospitals—

''(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

''(B) to determine the referral patterns of physician owners, including the percentage of patients they re-

ferred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

''(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

''(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

''(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.''

GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS

Pub. L. 101–239, title VI, § 6204(e), Dec. 19, 1989, 103 Stat. 2242, directed Comptroller General to conduct a study of ownership of hospitals and other providers of medicare services by referring physicians and, by not later than Feb. 1, 1991, report to Congress on results of such study, prior to repeal by Pub. L. 104–316, title I, § 122(h)(1), Oct. 19, 1996, 110 Stat. 3837.

STATISTICAL SUMMARY OF COMPARATIVE UTILIZATION

Pub. L. 101–239, title VI, § 6204(f), Dec. 19, 1989, 103 Stat. 2243, as amended by Pub. L. 101–508, title IV, § 4207(e)(4)(A), formerly § 4027(e)(4)(A), Nov. 5, 1990, 104 Stat. 1388–122, renumbered Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–316, title I, § 122(h)(2), Oct. 19, 1996, 110 Stat. 3837, directed Secretary of Health and Human Services, not later than June 30, 1992, to submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in subsec. (f) of this section (other than entities providing clinical laboratory services).

§ 1395*oo*. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the ''Board'') which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of sec-

tion 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS–18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term ''provider of services'' includes a rural health clinic and a Federally qualified health center.

(Aug. 14, 1935, ch. 531, title XVIII, § 1878, as added Pub. L. 92–603, title II, § 243(a), Oct. 30, 1972, 86 Stat. 1420; amended Pub. L. 93–484, § 3(a), Oct. 26, 1974, 88 Stat. 1459; Pub. L. 96–499, title IX, § 955, Dec. 5, 1980, 94 Stat. 2647; Pub. L. 98–21, title VI, § 602(h), Apr. 20, 1983, 97 Stat. 165; Pub. L. 98–369, div. B, title III, §§ 2351(a)(1), (b)(1), 2354(b)(39), (40), July 18, 1984, 98 Stat. 1098, 1099, 1102; Pub. L. 101–508, title IV, § 4161(a)(6), (b)(4), Nov. 5, 1990, 104 Stat. 1388–94, 1388–95; Pub. L. 103–66, title XIII, § 13503(c)(1)(B), Aug. 10, 1993, 107 Stat. 579.)

Editorial Notes

AMENDMENTS

1993—Subsec. (f)(2). Pub. L. 103–66 substituted ''the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which'' for ''the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time''.

1990—Subsec. (j). Pub. L. 101–508, § 4161(b)(4), inserted ''a rural health clinic and'' after ''includes''.

Pub. L. 101–508, § 4161(a)(6), added subsec. (j).

1984—Subsec. (c). Pub. L. 98–369, § 2354(b)(39), substituted ''inadmissible'' for ''inadmissable''.

Subsec. (e). Pub. L. 98–369, § 2354(b)(40), substituted ''and (e)'' for '', (e), and (f)''.

Subsec. (f)(1). Pub. L. 98–369, § 2351(a)(1), substituted ''notification of such determination is received'' for ''such determination is rendered'' in third sentence.

Pub. L. 98–369, § 2351(b)(1), inserted ''or which have obtained a hearing under subsection (b)'' after ''common ownership or control'' in last sentence.

1983—Subsec. (a). Pub. L. 98–21, § 602(h)(1)(A), inserted provision in introductory text that, except as provided in subsec. (g)(2) of this section, any hospital which receives payments in amounts computed under section 1395ww(b) or (d) of this title and which has submitted such reports within such time as Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by Board.

Subsec. (a)(1)(A). Pub. L. 98–21, § 602(h)(1)(B), (C), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(3). Pub. L. 98–21, § 602(h)(1)(D), substituted ''(1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination,'' for ''(1)(A)''.

Subsec. (f)(1). Pub. L. 98–21, § 602(h)(2), inserted ''(or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located)'' after ''the judicial district in which the provider is located'', and ''Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers.''

Subsec. (g). Pub. L. 98–21, § 602(h)(3), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 98–21, § 602(h)(4), substituted ''payment of providers of services'' for ''cost reimbursement''.

1980—Subsec. (f)(1). Pub. L. 96–499 inserted provision empowering providers of services to obtain judicial review of any action of a fiscal intermediary involving a question of law or regulations relevant to matters in controversy whenever Board determined that it was without authority to decide such matters in controversy.

1974—Subsec. (f). Pub. L. 93–484 redesignated existing provisions as par. (1), inserted provisions authorizing judicial review for providers of final decisions of Board and judicial review of any affirmance by Secretary, and added pars. (2) and (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective Oct. 1, 1993, see section 13503(c)(2) of Pub. L. 103–66, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4161(a)(6) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(a)(8)(C) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(b)(4) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(b)(5) of Pub. L. 101–508, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2351(a)(2), July 18, 1984, 98 Stat. 1099, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective with respect to any civil action commenced on or after the date of the enactment of this Act [July 18, 1984].''

Pub. L. 98–369, div. B, title III, § 2351(b)(2), July 18, 1984, 98 Stat. 1099, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(39), (40) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title. See, also, section 2351(c) of Pub. L. 98–369, set out as a note below.

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–484, § 3(b), Oct. 26, 1974, 88 Stat. 1459, provided that: ''The amendment made by subsection (a) [amending this section] shall be applicable to cost reports of providers of services for accounting periods ending on or after June 30, 1973.''

EFFECTIVE DATE

Pub. L. 92–603, title II, § 243(c), Oct. 30, 1972, 86 Stat. 1422, provided that: ''The amendments made by this section [enacting this section and amending section 1395h of this title] shall apply with respect to cost reports of providers of services, as defined in title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], for accounting periods ending on or after June 30, 1973.''

REFERENCES IN OTHER LAWS TO GS–16, 17, OR 18 PAY RATES

References in laws to the rates of pay for GS–16, 17, or 18, or to maximum rates of pay under the General Schedule, to be considered references to rates payable under specified sections of Title 5, Government Organization and Employees, see section 529 [title I, § 101(c)(1)] of Pub. L. 101–509, set out in a note under section 5376 of Title 5.

REVIEW OF PROVIDER REIMBURSEMENT REVIEW BOARD DECISIONS

Pub. L. 98–369, div. B, title III, § 2351(c), July 18, 1984, 98 Stat. 1099, provided that: ''Notwithstanding section 604 of the Social Security Amendments of 1983 (Public Law 98–21) [set out as an Effective Date of 1983 Amendments note under section 1395ww of this title]—

''(1) the amendments made by section 602(h)(2)(A) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after April 20, 1983; and

''(2) the amendments made by section 602(h)(2)(B) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984].''

§ 1395pp. Limitation on liability where claims are disallowed

(a) Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this subchapter for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) and section 1395y(a)(9) of this title did not apply and as though the coverage denial described in subsection (g) had not occurred. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

(b) Knowledge of person or provider that payment could not be made; indemnification of individual

In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs) for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services. No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this subchapter.

(c) Knowledge of both provider and individual to whom items or services were furnished that payment could not be made

No payments shall be made under this subchapter in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1395y(a)(1) or (a)(9) of this title or by reason of a coverage denial described in subsection (g).

(d) Exercise of rights

In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under sections 1395ff(b) and 1395u(b)(3)(C) of this title (as may be applicable) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Payment where beneficiary not at fault

Where payment for inpatient hospital services or extended care services may not be made under part A of this subchapter on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1395x(e) or (j) of this title by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, quality improvement organization, or

fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

(f) Presumption with respect to coverage denial; rebuttal; requirements; "fiscal intermediary" defined

(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2).

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this subchapter with respect to the services.

(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The agency complies with requirements of the Secretary under this subchapter respecting timely submittal of bills for payment and medical documentation.

(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this subchapter.

(4)(A) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.

(5) In this subsection, the term ''fiscal intermediary'' means, with respect to a home health agency, an agency or organization with an agreement under section 1395h of this title with respect to the agency.

(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

(g) Coverage denial defined

The coverage denial described in this subsection is—

(1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1395f(a)(2)(C) of this title or section 1395n(a)(2)(A) of this title in that the individual—

(A) is or was not confined to his home, or

(B) does or did not need skilled nursing care on an intermittent basis; and

(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

(h) Supplier responsibility for items furnished on assignment basis

If a supplier of medical equipment and supplies (as defined in section 1395m(j)(5) of this title)—

(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(j)(1) of this title;

(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1395m(a)(15) of this title; or

(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(a)(17)(B) of this title,

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1395m(a)(18) of this title shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.

(i) Hospice program eligibility recertification

The provisions of this section shall apply with respect to a denial of a payment under this subchapter by reason of section 1395f(a)(7)(E) of this title in the same manner as such provisions apply with respect to a denial of a payment under this subchapter by reason of section 1395y(a)(1) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1879, as added Pub. L. 92–603, title II, § 213(a), Oct. 30, 1972, 86 Stat. 1384; amended Pub. L. 96–499, title IX, § 956(a), Dec. 5, 1980, 94 Stat. 2648; Pub. L. 97–248, title I, §§ 145, 148(e), Sept. 3, 1982, 96 Stat. 393, 394; Pub. L. 99–509, title IX, §§ 9305(g)(1), 9341(a)(3), Oct. 21, 1986, 100 Stat. 1991, 2038; Pub. L. 100–203, title IV, § 4096(b), Dec. 22, 1987, 101 Stat. 1330–139; Pub. L. 101–239, title VI, § 6214(a), (b), Dec. 19, 1989, 103 Stat. 2252; Pub. L. 103–432, title I, § 133(b), Oct. 31, 1994, 108 Stat. 4421; Pub. L. 105–33, title IV, § 4447, Aug. 5, 1997, 111 Stat. 424; Pub. L. 112–40, title II, § 261(a)(3)(A), (B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 113–185, § 3(b), Oct. 6, 2014, 128 Stat. 1969.)

Editorial Notes

AMENDMENTS

2014—Subsec. (i). Pub. L. 113–185 added subsec. (i).

2011—Subsec. (a). Pub. L. 112–40, § 261(a)(3)(A), substituted ''quality improvement'' for ''utilization and quality control peer review'' in concluding provisions.

Subsec. (e). Pub. L. 112–40, § 261(a)(3)(B), substituted ''quality improvement'' for ''quality control and peer review''.

1997—Subsec. (g). Pub. L. 105–33 substituted ''subsection is—'' for ''subsection is,'', redesignated remaining text as par. (1) and former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, substituted ''; and'' for period at end, and added par. (2).

1994—Subsec. (h). Pub. L. 103–432 added subsec. (h).

1989—Subsec. (f)(1). Pub. L. 101–239, § 6214(a)(1), struck out ''with respect to any coverage denial described in subsection (g) of this section'' before period at end.

Subsec. (f)(4). Pub. L. 101–239, § 6214(a)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (f)(6). Pub. L. 101–239, § 6214(b), added par. (6).

1987—Subsec. (b). Pub. L. 100–203 struck out '', subject to the deductible and coinsurance provisions of this subchapter,'' after ''(referred to in such paragraphs)'' and inserted at end ''No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this subchapter.''

1986—Subsec. (a). Pub. L. 99–509, § 9305(g)(1)(A)–(C), inserted in par. (1) ''or by reason of a coverage denial described in subsection (g)'', and in concluding provisions inserted ''and as though the coverage denial described in subsection (g) had not occurred'' and ''or by reason of a coverage denial described in subsection (g)''.

Subsec. (c). Pub. L. 99–509, § 9305(g)(1)(D), inserted ''or by reason of a coverage denial described in subsection (g)''.

Subsec. (d). Pub. L. 99–509, § 9341(a)(3), substituted ''sections 1395ff(b) and 1395u(b)(3)(C) of this title (as may be applicable)'' for ''section 1395ff(b) of this title (when the determination is under part A) or section 1395u(b)(3)(C) of this title (when the determination is under part B)''.

Subsecs. (f), (g). Pub. L. 99–509, § 9305(g)(1)(E), added subsecs. (f) and (g).

1982—Subsec. (a). Pub. L. 97–248, § 145, inserted provisions relating to imputing knowledge to provider or other person furnishing items or services for which payment may not be made that payment may not be made if the provider or other person has been notified that a pattern of inappropriate utilization has occurred in the past and there has been a reasonable time for correction of such utilization.

Subsec. (e). Pub. L. 97–248, § 148(e), substituted ''quality control and peer review organization'' for ''professional standards review organization''.

1980—Subsec. (e). Pub. L. 96–499 added subsec. (e).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to items or services furnished on or after Jan. 1, 1995, see section 133(c) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6214(c), Dec. 19, 1989, 103 Stat. 2252, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to determinations for quarters beginning on or after the date of the enactment of this Act [Dec. 19, 1989].''

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9305(g)(3), Oct. 21, 1986, 100 Stat. 1993, as amended by Pub. L. 100–360, title IV, § 426(c), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, § 4207(b)(3), formerly § 4027(b)(3), Nov. 5, 1990, 104 Stat. 1388–118, renumbered Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to coverage denials occurring on or after July 1, 1987, and before December 31, 1995.''

Amendment by section 9341(a)(3) of Pub. L. 99–509 applicable to items and services furnished on or after Jan. 1, 1987, see section 9341(b) of Pub. L. 99–509, set out as a note under section 1395ff of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, § 956(b), Dec. 5, 1980, 94 Stat. 2648, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1981.''

EFFECTIVE DATE

Pub. L. 92–603, title II, § 213(b), Oct. 30, 1972, 86 Stat. 1386, provided that: ''The amendments made by this section [enacting this section] shall be effective with respect to claims under part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], filed with respect to items or services furnished after the date of the enactment of this Act [Oct. 30, 1972].''

PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS

Pub. L. 108–173, title IX, § 938(c), Dec. 8, 2003, 117 Stat. 2415, provided that:

''(1) DATA COLLECTION.—The Secretary [of Health and Human Services] shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

''(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

''(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act [42 U.S.C. 1395ff(h)] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act [42 U.S.C. 1395 et seq.]. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

''(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act [42 U.S.C. 1395ff(h)] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

''(A) information concerning—

''(i) the number and types of procedures for which a prior determination has been sought;

''(ii) determinations made under the process;

''(iii) the percentage of beneficiaries prevailing;

''(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

''(v) changes in receipt of services resulting from the application of such process;

''(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

''(C) recommendations for improvements or continuation of such process.

''(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term 'advance beneficiary notice' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act [42 U.S.C. 1395c et seq., 1395j et seq.] before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title [42 U.S.C. 1395 et seq.].''

REPORTS TO CONGRESS ON DENIALS OF BILLS FOR PAYMENT

Pub. L. 99–509, title IX, § 9305(g)(2), Oct. 21, 1986, 100 Stat. 1992, directed Secretary of Health and Human Services to report to Congress annually in March of 1987 and 1988 information on frequency and distribution (by type of provider) of denials of bills for payment under this subchapter for extended care services, home health services, and hospice care, by reason of section 1395y(a)(1) or (9) of this title, and coverage denials described in subsec. (g) of this section, and such other information as appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

§ 1395qq. Indian Health Service facilities

(a) Eligibility for payments; conditions and requirements

A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for payments under this subchapter, notwithstanding sections 1395f(c) and 1395n(d) of this title, if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this subchapter.

(b) Eligibility based on submission of plan to achieve compliance with conditions and requirements; twelve-month period

Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this subchapter which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Payments into special fund for improvements to achieve compliance with conditions and requirements; certification of compliance by Secretary

Notwithstanding any other provision of this subchapter, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this subchapter. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) Report by Secretary; status of facilities in complying with conditions and requirements

The annual report of the Secretary which is required by section 1671 of title 25 shall include (along with the matters specified in section 1643 of title 25) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this subchapter and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

(e) Services provided by Indian Health Service, Indian tribe, or tribal organization

(1)(A) Notwithstanding section 1395n(d) of this title, subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) (and for items and services furnished on or after January 1, 2005, all items and services for which payment may be made under part B) furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

(B) Payment shall not be made for services under subparagraph (A) to the extent that payment is otherwise made for such services under this subchapter.

(2) The services described in this paragraph are the following:

(A) Services for which payment is made under section 1395w–4 of this title.

(B) Services furnished by a practitioner described in section 1395u(b)(18)(C) of this title for which payment under part B is made under a fee schedule.

(C) Services furnished by a physical therapist or occupational therapist as described in section 1395x(p) of this title for which payment under part B is made under a fee schedule.

(3) Subsection (c) shall not apply to payments made under this subsection.

(f) Cross reference

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of title 25.[1]

(Aug. 14, 1935, ch. 531, title XVIII, § 1880, as added Pub. L. 94–437, title IV, § 401(b), Sept. 30, 1976, 90 Stat. 1408; amended Pub. L. 102–573, title VII, § 701(d), Oct. 29, 1992, 106 Stat. 4572; Pub. L. 106–417, § 3(b)(1), Nov. 1, 2000, 114 Stat. 1815; Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525; Pub. L. 108–173, title VI, § 630, Dec. 8, 2003, 117 Stat. 2321; Pub. L. 111–148, title II, § 2902(a), title X, § 10221(a), (b)(4), Mar. 23, 2010, 124 Stat. 333, 935, 936.)

Editorial Notes

REFERENCES IN TEXT

Section 1645 of title 25, referred to in subsec. (f), was amended generally by section 10221(a) of title X of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains provisions relating to direct billing of medicare, medicaid, and other third party payors.

CODIFICATION

Pub. L. 111–148, § 10221(a), enacted into law S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, ''[e]xcept as provided in'' section 10221(b) of Pub. L. 111–148. Section 201(a) of S. 1790 would have amended this section but was stricken out by section 10221(b)(4) of Pub. L. 111–148.

AMENDMENTS

2010—Subsec. (e)(1)(A). Pub. L. 111–148, § 2902(a), substituted ''on or after'' for ''during the 5-year period beginning on''.

2003—Subsec. (e)(1)(A). Pub. L. 108–173 inserted ''(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)'' after ''for services described in paragraph (2)''.

2000—Subsec. (e). Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)(2)], added subsec. (e). Former subsec. (e) redesignated (f).

Pub. L. 106–417 added subsec. (e).

Subsec. (f). Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)(1)], redesignated subsec. (e) as (f).

1992—Subsec. (d). Pub. L. 102–573 made technical amendment to the reference to section 1671 of title 25 to reflect renumbering of corresponding section of original act.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, § 2902(b), Mar. 23, 2010, 124 Stat. 333, provided that: ''The amendments made by this section [amending this section] shall apply to items or services furnished on or after January 1, 2010.''

[1] See References in Text note below.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title IV, § 432(a)] of Pub. L. 106–554 applicable to services furnished on or after July 1, 2001, see section 1(a)(6) [title IV, § 432(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by Pub. L. 106–417 effective Oct. 1, 2000, see section 3(c) of Pub. L. 106–417, set out as a note under section 1645 of Title 25, Indians.

MEDICARE PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Pub. L. 94–437, title IV, § 401(c), Sept. 30, 1976, 90 Stat. 1409, provided that any payments received for services provided to beneficiaries under this section were not to be considered in determining appropriations for health care and services to Indians, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

PREFERENCE IN SERVICES FOR INDIANS WITH MEDICARE COVERAGE NOT AUTHORIZED

Pub. L. 94–437, title IV, § 401(d), Sept. 30, 1976, 90 Stat. 1409, which provided that nothing in this section authorized the Secretary to provide services to an Indian beneficiary with coverage under this subchapter, in preference to an Indian beneficiary without such coverage, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(b) of Pub. L. 94–437, which is classified to section 1641(b) of Title 25, Indians.

§ 1395rr. End stage renal disease program

(a) Type, duration, and scope of benefits

The benefits provided by parts A and B of this subchapter shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 426–1 of this title, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this subchapter, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been determined to have end stage renal disease and who are entitled to such benefits without regard to section 426–1 of this title shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

(b) Payments with respect to services; dialysis; regulations; physicians' services; target reimbursement rates; home dialysis supplies and equipment; self-care home dialysis support services; self-care dialysis units; hepatitis B vaccine

(1) Payments under this subchapter with respect to services, in addition to services for which payment would otherwise be made under this subchapter, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-

care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A)(i) of this subsection, (B) payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1395x(s)(2)(P)[1] of this title if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section). The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for transplantations. Beginning 180 days after February 9, 2018, an initial survey of a provider of services or a renal dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider's enrollment status indicates approval is pending the results of such survey.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease for which payments may be made under part B of this subchapter, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this subchapter, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1395x(v) of this title or section 1395ww of this title (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1395*l*(b) of this title.

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

(C) Such regulations, in the case of services furnished by proprietary providers and facilities (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1395x(v)(1)(B) of this title.

(D) For purposes of section 1395*oo* of this title, a renal dialysis facility shall be treated as a provider of services.

(3)(A) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(i) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

(ii) subject to subparagraph (B), on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations).

(B)(i) For purposes of subparagraph (A)(ii), subject to clauses (ii) and (iii), an individual determined to have end stage renal disease receiving home dialysis may choose to receive monthly end stage renal disease-related clinical assessments furnished on or after January 1, 2019, via telehealth.

(ii) Except as provided in clause (iii), clause (i) shall apply to an individual only if the individual receives a face-to-face clinical assessment, without the use of telehealth—

(I) in the case of the initial 3 months of home dialysis of such individual, at least monthly; and

(II) after such initial 3 months, at least once every 3 consecutive months.

(iii) The Secretary may waive the provisions of clause (ii) during the emergency period described in section 1320b–5(g)(1)(B) of this title.

(4)(A) Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)) or on the basis of a method established under paragraph (7).

(B) The Secretary shall make payments to a supplier of home dialysis supplies and equip-

[1] See References in Text note below.

ment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

(A) assume full responsibility for directly obtaining or arranging for the provision of—

(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

(ii) dialysis equipment maintenance and repair services;

(iii) the purchase and delivery of all necessary medical supplies; and

(iv) where necessary, the services of trained home dialysis aides;

(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility's home dialysis patient population; and

(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

(A) the Secretary's estimate of the cost of providing medically necessary home dialysis supplies and equipment;

(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event (except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target reimbursement rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure (including methods established under paragraph (7)) which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

(7) Subject to paragraph (12), the Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under

subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) the geographic size of the network area;

(B) the number of providers of end stage renal disease services in the network area;

(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

(D) the proportion of the aggregate administrative funds collected in the network area.

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, for such services furnished on or after January 1, 2001, and before January 1, 2005, by 2.4 percent above such composite rate payment amounts for such services furnished on December 31, 2000, and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004.

(8) For purposes of this subchapter, the term ''home dialysis supplies and equipment'' means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

(9) For purposes of this subchapter, the term ''self-care home dialysis support services'', to the extent permitted in regulation, means—

(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;

(B) installation and maintenance of dialysis equipment;

(C) testing and appropriate treatment of the water; and

(D) such additional supportive services as the Secretary finds appropriate and desirable.

(10) For purposes of this subchapter, the term ''self-care dialysis unit'' means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

(11)(A) Hepatitis B vaccine and its administration, when provided to a patient determined to have end stage renal disease, shall not be included as dialysis services for purposes of payment under any prospective payment amount or comprehensive fee established under this section. Payment for such vaccine and its administration shall be made separately in accordance with section 1395*l* of this title.

(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and subject to paragraphs (12) and (13) payment for such item shall be made separately—

(i) in the case of erythropoietin provided by a physician, in accordance with section 1395*l* of this title; and

(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

(I) for erythropoietin provided during 1994, in an amount equal to $10 per thousand units (rounded to the nearest 100 units), and

(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.

(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.

(12)(A) Subject to paragraph (14), in lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics. Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

(B) The system described in subparagraph (A) shall include—

(i) the services comprising the composite rate established under paragraph (7); and

(ii) the difference between payment amounts under this subchapter for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—

(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this subchapter shall be determined using the methodology specified in paragraph (13)(A)(i).

(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Except as provided in subparagraph (G), nothing in this paragraph or paragraph (14) shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B) or under the system under paragraph (14).

(G) The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services—

(i) furnished on or after January 1, 2006, and before April 1, 2007, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005;

(ii) furnished on or after April 1, 2007, and before January 1, 2009, by 1.6 percent above the amount of such composite rate component for such services furnished on March 31, 2007;

(iii) furnished on or after January 1, 2009, and before January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2008; and

(iv) furnished on or after January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2009.

(H) There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13).

(13)(A) Subject to paragraph (14), the payment amounts under this subchapter for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1395u(*o*)(1)(A)(v) of this title for the drug or biological.

(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1395w–3a of this title for the drug or biological, as the Secretary may specify.

(B) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before December 8, 2003, shall continue to be separately billed on and after such date, subject to paragraph (14).

(14)(A)(i) Subject to subparagraph (E), for services furnished on or after January 1, 2011, the Secretary shall implement a payment system under which a single payment is made under this subchapter to a provider of services or a

renal dialysis facility for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) and for such services and items furnished pursuant to paragraph (4).

(ii) In implementing the system under this paragraph the Secretary shall ensure that the estimated total amount of payments under this subchapter for 2011 for renal dialysis services shall equal 98 percent of the estimated total amount of payments for renal dialysis services, including payments under paragraph (12)(B)(ii), that would have been made under this subchapter with respect to services furnished in 2011 if such system had not been implemented. In making the estimation under subclause (I), the Secretary shall use per patient utilization data from 2007, 2008, or 2009, whichever has the lowest per patient utilization.

(B) For purposes of this paragraph, the term ''renal dialysis services'' includes—

(i) items and services included in the composite rate for renal dialysis services as of December 31, 2010;

(ii) erythropoiesis stimulating agents and any oral form of such agents that are furnished to individuals for the treatment of end stage renal disease;

(iii) other drugs and biologicals that are furnished to individuals for the treatment of end stage renal disease and for which payment was (before the application of this paragraph) made separately under this subchapter, and any oral equivalent form of such drug or biological; and

(iv) diagnostic laboratory tests and other items and services not described in clause (i) that are furnished to individuals for the treatment of end stage renal disease.

Such term does not include vaccines.

(C) The system under this paragraph may provide for payment on the basis of services furnished during a week or month or such other appropriate unit of payment as the Secretary specifies.

(D) Such system—

(i) shall include a payment adjustment based on case mix that may take into account patient weight, body mass index, comorbidities, length of time on dialysis, age, race, ethnicity, and other appropriate factors;

(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management;

(iii) shall include a payment adjustment that reflects the extent to which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services, and for payment for renal dialysis services furnished on or after January 1, 2011, and before January 1, 2014, such payment adjustment shall not be less than 10 percent; and

(iv) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

(I) for pediatric providers of services and renal dialysis facilities;

(II) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate; and

(III) for providers of services or renal dialysis facilities located in rural areas.

The Secretary shall take into consideration the unique treatment needs of children and young adults in establishing such system.

(E)(i) The Secretary shall provide for a four-year phase-in (in equal increments) of the payment amount under the payment system under this paragraph, with such payment amount being fully implemented for renal dialysis services furnished on or after January 1, 2014.

(ii) A provider of services or renal dialysis facility may make a one-time election to be excluded from the phase-in under clause (i) and be paid entirely based on the payment amount under the payment system under this paragraph. Such an election shall be made prior to January 1, 2011, in a form and manner specified by the Secretary, and is final and may not be rescinded.

(iii) The Secretary shall make an adjustment to the payments under this paragraph for years during which the phase-in under clause (i) is applicable so that the estimated total amount of payments under this paragraph, including payments under this subparagraph, shall equal the estimated total amount of payments that would otherwise occur under this paragraph without such phase-in.

(F)(i)(I) Subject to subclauses (II) and (III) and clause (ii), beginning in 2012, the Secretary shall annually increase payment amounts established under this paragraph by an ESRD market basket percentage increase factor for a bundled payment system for renal dialysis services that reflects changes over time in the prices of an appropriate mix of goods and services included in renal dialysis services. In order to accomplish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.

(II) Subject to subclause (III), for 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.

(III) Notwithstanding subclauses (I) and (II), in order to accomplish the purposes of subparagraph (I) with respect to 2015, the increase factor described in subclause (I) for 2015 shall be 0.0 percent pursuant to the regulation issued by the Secretary on December 2, 2013, entitled ''Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule'' (78 Fed. Reg. 72156).

(ii) For years during which a phase-in of the payment system pursuant to subparagraph (E) is applicable, the following rules shall apply to the portion of the payment under the system that is based on the payment of the composite rate that would otherwise apply if the system under this paragraph had not been enacted:

(I) The update under clause (i) shall not apply.

(II) Subject to clause (i)(II), the Secretary shall annually increase such composite rate by the ESRD market basket percentage increase factor described in clause (i)(I).

(G) There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the determination of payment amounts under subparagraph (A), the establishment of an appropriate unit of payment under subparagraph (C), the identification of renal dialysis services included in the bundled payment, the adjustments under subparagraph (D), the application of the phase-in under subparagraph (E), and the establishment of the market basket percentage increase factors under subparagraph (F).

(H) Erythropoiesis stimulating agents and other drugs and biologicals shall be treated as prescribed and dispensed or administered and available only under part B if they are—

(i) furnished to an individual for the treatment of end stage renal disease; and

(ii) included in subparagraph (B) for purposes of payment under this paragraph.

(I) For services furnished on or after January 1, 2014, and before January 1, 2015, the Secretary shall, by comparing per patient utilization data from 2007 with such data from 2012, make reductions to the single payment that would otherwise apply under this paragraph for renal dialysis services to reflect the Secretary's estimate of the change in the utilization of drugs and biologicals described in clauses (ii), (iii), and (iv) of subparagraph (B) (other than oral-only ESRD-related drugs, as such term is used in the final rule promulgated by the Secretary in the Federal Register on August 12, 2010 (75 Fed. Reg. 49030)). In making reductions under the preceding sentence, the Secretary shall take into account the most recently available data on average sales prices and changes in prices for drugs and biological[2] reflected in the ESRD market basket percentage increase factor under subparagraph (F).

(c) Renal disease network areas; coordinating councils, executive committees, and medical review boards; national end stage renal disease medical information system; functions of network organizations

(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1395x(s)(2)(F) of this title, or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment set-

[2] So in original. Probably should be ''biologicals''.

tings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and to assure the maintenance of the registry established under paragraph (7);

(G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

(H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals or to follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation.

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

(A) the preparation of the annual report to the Congress required under subsection (g);[1]

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

(8) The provisions of sections 1320c–6 and 1320c–9 of this title shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.

(d) Donors of kidney for transplant surgery

Notwithstanding any provision to the contrary in section 426 of this title any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this subchapter with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this subchapter), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this subchapter without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

(e) Reimbursement of providers, facilities, and nonprofit entities for costs of artificial kidney and automated dialysis peritoneal machines for home dialysis

(1) Notwithstanding any other provision of this subchapter, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities, and nonprofit entities (without regard to the deductible and coinsurance provisions of this subchapter) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider, facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term ''supportive equipment'' includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

(f) Experiments, studies, and pilot projects

(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this subchapter, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this subchapter (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

(B) With respect to dialysis services furnished on or after January 1, 1988 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines), no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialy-

sis treatment not furnished in compliance with such a protocol or in violation of such requirement.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g) Conditional approval of dialysis facilities; restriction-of-payments notice to public and facility; notice and hearing; judicial review

(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A),

(B) finds that the facility's deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this subchapter shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary's decision to restrict payments under this subsection shall be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A), or (B) the Secretary terminates the agreement under this subchapter with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(h) Quality incentives in the end-stage renal disease program

(1) Quality incentives

(A) In general

With respect to renal dialysis services (as defined in subsection (b)(14)(B)) furnished on or after January 1, 2012, in the case of a provider of services or a renal dialysis facility that does not meet the requirement described in subparagraph (B) with respect to the year, payments otherwise made to such provider or facility under the system under subsection (b)(14) for such services shall be reduced by up to 2.0 percent, as determined appropriate by the Secretary.

(B) Requirement

The requirement described in this subparagraph is that the provider or facility meets (or exceeds) the total performance score under paragraph (3) with respect to performance standards established by the Secretary with respect to measures specified in paragraph (2).

(C) No effect in subsequent years

The reduction under subparagraph (A) shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the single payment amount under the system under paragraph (14) in a subsequent year.

(2) Measures

(A) In general

The measures specified under this paragraph with respect to the year involved shall include—

(i) measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management and measures on dialysis adequacy;

(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify;

(iii) for 2016 and subsequent years, measures described in subparagraph (E)(i); and

(iv) such other measures as the Secretary specifies, including, to the extent feasible, measures on—

(I) iron management;

(II) bone mineral metabolism; and

(III) vascular access, including for maximizing the placement of arterial venous fistula.

(B) Use of endorsed measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iv) must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Updating measures

The Secretary shall establish a process for updating the measures specified under subparagraph (A) in consultation with interested parties.

(D) Consideration

In specifying measures under subparagraph (A), the Secretary shall consider the availability of measures that address the

unique treatment needs of children and young adults with kidney failure.

(E) Measures specific to the conditions treated with oral-only drugs

(i) In general

The measures described in this subparagraph are measures specified by the Secretary that are specific to the conditions treated with oral-only drugs. To the extent feasible, such measures shall be outcomes-based measures.

(ii) Consultation

In specifying the measures under clause (i), the Secretary shall consult with interested stakeholders.

(iii) Use of endorsed measures

(I) In general

Subject to subclause (I), any measures specified under clause (i) must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(II) Exception

If the entity with a contract under section 1395aaa(a) of this title has not endorsed a measure for a specified area or topic related to measures described in clause (i) that the Secretary determines appropriate, the Secretary may specify a measure that is endorsed or adopted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease.

(3) Performance scores

(A) Total performance score

(i) In general

Subject to clause (ii), the Secretary shall develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance standards with respect to the measures selected under paragraph (2) for a performance period established under paragraph (4)(D) (in this subsection referred to as the ''total performance score'').

(ii) Application

For providers of services and renal dialysis facilities that do not meet (or exceed) the total performance score established by the Secretary, the Secretary shall ensure that the application of the methodology developed under clause (i) results in an appropriate distribution of reductions in payment under paragraph (1) among providers and facilities achieving different levels of total performance scores, with providers and facilities achieving the lowest total performance scores receiving the largest reduction in payment under paragraph (1)(A).

(iii) Weighting of measures

In calculating the total performance score, the Secretary shall weight the scores with respect to individual measures calculated under subparagraph (B) to reflect priorities for quality improvement, such as weighting scores to ensure that providers of services and renal dialysis facilities have strong incentives to meet or exceed anemia management and dialysis adequacy performance standards, as determined appropriate by the Secretary.

(B) Performance score with respect to individual measures

The Secretary shall also calculate separate performance scores for each measure, including for dialysis adequacy and anemia management.

(4) Performance standards

(A) Establishment

Subject to subparagraph (E), the Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period with respect to a year (as established under subparagraph (D)).

(B) Achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement, as determined appropriate by the Secretary.

(C) Timing

The Secretary shall establish the performance standards under subparagraph (A) prior to the beginning of the performance period for the year involved.

(D) Performance period

The Secretary shall establish the performance period with respect to a year. Such performance period shall occur prior to the beginning of such year.

(E) Special rule

The Secretary shall initially use as the performance standard for the measures specified under paragraph (2)(A)(i) for a provider of services or a renal dialysis facility the lesser of—

(i) the performance of such provider or facility for such measures in the year selected by the Secretary under the second sentence of subsection (b)(14)(A)(ii); or

(ii) a performance standard based on the national performance rates for such measures in a period determined by the Secretary.

(5) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(A) The determination of the amount of the payment reduction under paragraph (1).

(B) The establishment of the performance standards and the performance period under paragraph (4).

(C) The specification of measures under paragraph (2).

(D) The methodology developed under paragraph (3) that is used to calculate total performance scores and performance scores for individual measures.

(6) Public reporting

(A) In general

The Secretary shall establish procedures for making information regarding performance under this subsection available to the public, including—

(i) the total performance score achieved by the provider of services or renal dialysis facility under paragraph (3) and appropriate comparisons of providers of services and renal dialysis facilities to the national average with respect to such scores; and

(ii) the performance score achieved by the provider or facility with respect to individual measures.

(B) Opportunity to review

The procedures established under subparagraph (A) shall ensure that a provider of services and a renal dialysis facility has the opportunity to review the information that is to be made public with respect to the provider or facility prior to such data being made public.

(C) Certificates

(i) In general

The Secretary shall provide certificates to providers of services and renal dialysis facilities who furnish renal dialysis services under this section to display in patient areas. The certificate shall indicate the total performance score achieved by the provider or facility under paragraph (3).

(ii) Display

Each facility or provider receiving a certificate under clause (i) shall prominently display the certificate at the provider or facility.

(D) Web-based list

The Secretary shall establish a list of providers of services and renal dialysis facilities who furnish renal dialysis services under this section that indicates the total performance score and the performance score for individual measures achieved by the provider and facility under paragraph (3). Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format.

(Aug. 14, 1935, ch. 531, title XVIII, § 1881, as added Pub. L. 95–292, § 2, June 13, 1978, 92 Stat. 308; amended Pub. L. 96–499, title IX, § 957, Dec. 5, 1980, 94 Stat. 2648; Pub. L. 97–35, title XXI, § 2145(a), Aug. 13, 1981, 95 Stat. 799; Pub. L. 98–21, title VI, § 602(i), Apr. 20, 1983, 97 Stat. 165; Pub. L. 98–369, div. B, title III, §§ 2323(c), 2352(a), 2354(b)(41), July 18, 1984, 98 Stat. 1086, 1099, 1102; Pub. L. 98–617, § 3(b)(8), Nov. 8, 1984, 98 Stat. 3296; Pub. L. 99–509, title IX, § 9335(a)(2), (d)(1), (e)–(i)(1), (j)(1), (k)(1), Oct. 21, 1986, 100 Stat. 2029–2033; Pub. L. 100–93, § 12, Aug. 18, 1987, 101 Stat. 697; Pub. L. 100–203, title IV, §§ 4036(b), (c)(2), (d)(5), 4065(b), Dec. 22, 1987, 101 Stat. 1330–79, 1330–80, 1330–112; Pub. L. 101–239, title VI, §§ 6102(e)(8), 6203(b)(1), (2), 6219(a), (b), Dec. 19, 1989, 103 Stat. 2188, 2235, 2254; Pub. L. 101–508, title IV, § 4201(c)(1), (d)(2), formerly (d)(2), (3), Nov. 5, 1990, 104 Stat. 1388–103, 1388–104, renumbered Pub. L. 103–432, title I, § 160(d)(3), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 103–66, title XIII, § 13566(a), Aug. 10, 1993, 107 Stat. 607; Pub. L. 103–296, title I, § 108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 222(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352; Pub. L. 106–554, § 1(a)(6) [title IV, § 422(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516; Pub. L. 108–173, title VI, § 623(a), (b)(2), (d), Dec. 8, 2003, 117 Stat. 2312, 2313; Pub. L. 109–171, title V, § 5106, Feb. 8, 2006, 120 Stat. 42; Pub. L. 109–432, div. B, title I, § 103(a), Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–275, title I, § 153(a), (b)(1), (3)(A), (c), July 15, 2008, 122 Stat. 2553, 2556; Pub. L. 111–148, title III, § 3401(h), Mar. 23, 2010, 124 Stat. 485; Pub. L. 112–240, title VI, § 632(a), Jan. 2, 2013, 126 Stat. 2354; Pub. L. 113–93, title II, § 217(b), (d), Apr. 1, 2014, 128 Stat. 1061, 1062; Pub. L. 115–123, div. E, title III, § 50302(a), (d), title IV, § 50403(b), Feb. 9, 2018, 132 Stat. 190, 192, 218; Pub. L. 116–136, div. A, title III, § 3705, Mar. 27, 2020, 134 Stat. 418.)

Editorial Notes

REFERENCES IN TEXT

Section 1395x(s)(2)(P) of this title, referred to in subsec. (b)(1), was redesignated section 1395x(s)(2)(O) of this title by Pub. L. 103–432, title I, § 147(f)(6)(B)(iii)(II), Oct. 31, 1994, 108 Stat. 4432.

Section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (b)(7), is section 1(a)(6) [title IV, § 422(a)(2)] of Pub. L. 106–554, which is set out as a note under this section.

Section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(12)(B)(ii), (13)(A)(ii), is section 623(c) of Pub. L. 108–173, which is set out as a note under this section.

Subsection (g), referred to in subsec. (c)(7)(A), was repealed, and subsec. (h) was redesignated (g), by Pub. L. 100–203, title IV, §§ 4036(d)(5)(C), (D), Dec. 22, 1987, 101 Stat. 1330–80.

AMENDMENTS

2020—Subsec. (b)(3)(B)(i). Pub. L. 116–136, § 3705(1), substituted ''clauses (ii) and (iii)'' for ''clause (ii)''.

Subsec. (b)(3)(B)(ii). Pub. L. 116–136, § 3705(2), substituted ''Except as provided in clause (iii), clause (i)'' for ''Clause (i)'' in introductory provisions.

Subsec. (b)(3)(B)(iii). Pub. L. 116–136, § 3705(3), added cl. (iii).

2018—Subsec. (b)(1). Pub. L. 115–123, § 50403(b), inserted at end: ''Beginning 180 days after February 9, 2018, an initial survey of a provider of services or a renal dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider's enrollment status indicates approval is pending the results of such survey.''

Pub. L. 115–123, § 50302(d), substituted ''paragraph (3)(A)(i)'' for ''paragraph (3)(A)''.

Subsec. (b)(3). Pub. L. 115–123, § 50302(a), inserted subpar. (A) designation before ''With respect to'', redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), substituted ''subject to subparagraph (B), on a comprehensive'' for ''on a comprehensive'' in cl. (ii), and added subpar. (B).

2014—Subsec. (b)(14)(F)(i)(I). Pub. L. 113–93, § 217(b)(2)(A), substituted ''subclauses (II) and (III)'' for ''subclause (II)'' and inserted at end ''In order to ac-

complish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.''

Subsec. (b)(14)(F)(i)(II). Pub. L. 113–93, §217(b)(2)(B), substituted ''Subject to subclause (III), for 2012'' for ''For 2012''.

Subsec. (b)(14)(F)(i)(III). Pub. L. 113–93, §217(b)(2)(C), added subcl. (III).

Subsec. (b)(14)(I). Pub. L. 113–93, §217(b)(1), inserted ''and before January 1, 2015,'' after ''January 1, 2014,''.

Subsec. (h)(2)(A)(iii), (iv). Pub. L. 113–93, §217(d)(1), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (h)(2)(B)(i). Pub. L. 113–93, §217(d)(2), substituted ''(A)(iv)'' for ''(A)(iii)''.

Subsec. (h)(2)(E). Pub. L. 113–93, §217(d)(3), added subpar. (E).

2013—Subsec. (b)(14)(I). Pub. L. 112–240 added subpar. (I).

2010—Subsec. (b)(14)(F)(i). Pub. L. 111–148, §3401(h)(1), designated existing provisions as subcl. (I), substituted ''subclause (II) and clause (ii)'' for ''clause (ii)'' and struck out ''minus 1.0 percentage point'' before period at end, and added subcl. (II).

Subsec. (b)(14)(F)(ii)(II). Pub. L. 111–148, §3401(h)(2), substituted ''Subject to clause (i)(II), the'' for ''The'' and ''clause (i)(I)'' for ''clause (i) minus 1.0 percentage point''.

2008—Subsec. (b)(12)(A). Pub. L. 110–275, §153(a)(2), (b)(3)(A)(i), substituted ''Subject to paragraph (14), in lieu of payment'' for ''In lieu of payment'' and inserted at end ''Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.''

Subsec. (b)(12)(F). Pub. L. 110–275, §153(b)(3)(A)(ii), in concluding provisions, inserted ''or paragraph (14)'' after ''this paragraph'' and ''or under the system under paragraph (14)'' after ''subparagraph (B)''.

Subsec. (b)(12)(G). Pub. L. 110–275, §153(a)(1), inserted ''and before January 1, 2009,'' after ''April 1, 2007,'' in cl. (ii) and added cls. (iii) and (iv).

Subsec. (b)(13)(A). Pub. L. 110–275, §153(b)(3)(A)(iii)(I), substituted ''Subject to paragraph (14), the payment amounts'' for ''The payment amounts'' in introductory provisions.

Subsec. (b)(13)(B). Pub. L. 110–275, §153(b)(3)(A)(iii)(II), redesignated cl. (i) as subpar. (B), inserted '', subject to paragraph (14)'' before period at end, and struck out cl. (ii) which read as follows: ''Nothing in this paragraph, section 1395u(*o*) of this title, section 1395w–3a of this title, or section 1395w–3b of this title shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.''

Subsec. (b)(14). Pub. L. 110–275, §153(b)(1), added par. (14).

Subsec. (h). Pub. L. 110–275, §153(c), added subsec. (h).

2006—Subsec. (b)(12)(F). Pub. L. 109–171, §5106(1), substituted ''Except as provided in subparagraph (G), nothing'' for ''Nothing'' in concluding provisions.

Subsec. (b)(12)(G). Pub. L. 109–432 amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: ''The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services furnished on or after January 1, 2006, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005.''

Pub. L. 109–171, §5106(3), added subpar. (G). Former subpar. (G) redesignated (H).

Subsec. (b)(12)(H). Pub. L. 109–171, §5106(2), redesignated subpar. (G) as (H).

2003—Subsec. (b)(7). Pub. L. 108–173, §623(a), (b)(2), (d)(2), in first sentence substituted ''Subject to paragraph (12), the Secretary'' for ''The Secretary'', in fourth sentence substituted ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary'' for ''The Secretary'', and, in concluding provisions, struck out ''and'' before ''for such services furnished on or after January 1, 2001,'', inserted ''and before January 1, 2005,'' after ''January 1, 2001,'', and inserted '', and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004'' before period at end.

Subsec. (b)(11)(B). Pub. L. 108–173, §623(d)(3), inserted ''subject to paragraphs (12) and (13)'' before ''payment for such item'' in introductory provisions.

Subsec. (b)(12), (13). Pub. L. 108–173, §623(d)(1), added pars. (12) and (13).

2000—Subsec. (b)(7). Pub. L. 106–554 substituted ''for such services furnished on or after January 1, 2001, by 2.4 percent'' for ''for such services furnished on or after January 1, 2001, by 1.2 percent'' in concluding provisions.

1999—Subsec. (b)(7). Pub. L. 106–113 inserted concluding provisions.

1994—Subsec. (g)(3). Pub. L. 103–296 inserted before period at end '', except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively''.

1993—Subsec. (b)(1)(C). Pub. L. 103–66, §13566(a)(1), substituted ''section 1395x(s)(2)(P)'' for ''section 1395x(s)(2)(Q)''.

Subsec. (b)(11)(B)(ii)(I). Pub. L. 103–66, §13566(a)(2), substituted ''1994'' for ''1991'' and ''$10'' for ''$11''.

1990—Subsec. (b)(1). Pub. L. 101–508, §4201(d)(2)(A), formerly §4201(d)(2), as renumbered by Pub. L. 103–432, §160(d)(3), added cl. (C).

Subsec. (b)(11). Pub. L. 101–508, §4201(d)(2)(B), formerly §4201(d)(3), as renumbered by Pub. L. 103–432, §160(d)(3), added subpar. (C).

Pub. L. 101–508, §4201(c)(1), designated existing provisions as subpar. (A) and added subpar. (B).

1989—Subsec. (b)(3)(A). Pub. L. 101–239, §6102(e)(8), inserted ''or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title'' after ''comparable services''.

Subsec. (b)(4). Pub. L. 101–239, §6203(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(7). Pub. L. 101–239, §6219(a), substituted ''organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—'' and subpars. (A) to (D) for ''network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).'' in last sentence.

Pub. L. 101–239, §6203(b)(1), inserted after second sentence ''The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities.''

Subsec. (c)(8). Pub. L. 101–239, §6219(b), added par. (8).

1987—Subsec. (b)(1). Pub. L. 100–203, §4036(b), substituted ''transplantations'' for ''covered procedures and for self-dialysis training programs''.

Subsec. (b)(2)(C). Pub. L. 100–203, § 4065(b), substituted ''facilities (other than hospital outpatient departments)'' for ''facilities''.

Subsec. (c)(2)(F). Pub. L. 100–203, § 4036(d)(5)(A), struck out ''and subsection (g) of this section'' after ''required by subparagraph (H)''.

Subsec. (c)(6). Pub. L. 100–203, § 4036(d)(5)(B), struck out at end ''The Secretary shall periodically submit to the Congress such legislative recommendations as the Secretary finds warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice.''

Subsec. (f)(7)(B). Pub. L. 100–203, § 4036(c)(2), inserted ''(or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines)'' after ''January 1, 1988''.

Subsec. (g). Pub. L. 100–203, § 4036(d)(5)(C), (D), redesignated subsec. (h) as (g) and struck out former subsec. (g) which directed the Secretary to submit to Congress on July 1, 1979, and on July 1 of each year thereafter a report on end stage renal disease program.

Subsec. (h). Pub. L. 100–203, § 4036(d)(5)(D), redesignated subsec. (h) as (g).

Pub. L. 100–93 added subsec. (h).

1986—Subsec. (b)(7). Pub. L. 99–509, § 9335(j)(1), inserted at end ''The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).''

Pub. L. 99–509, § 9335(a)(2), inserted ''and of pediatric facilities'' after ''isolated rural areas'' in third sentence, and inserted after third sentence ''Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed.''

Subsec. (c)(1)(A). Pub. L. 99–509, § 9335(d)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: ''For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.''

Subsec. (c)(1)(B). Pub. L. 99–509, § 9335(e), amended subpar. (B) generally, substituting ''network council and each medical review board'' for ''coordinating council and executive committee''.

Subsec. (c)(2)(A). Pub. L. 99–509, § 9335(f)(1), inserted ''and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs'' before the semicolon.

Subsec. (c)(2)(B). Pub. L. 99–509, § 9335(f)(2), inserted ''and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs'' before first semicolon.

Subsec. (c)(2)(D) to (F). Pub. L. 99–509, § 9335(f)(5), added subpars. (D) to (F). Former subpars. (D) and (E) redesignated (G) and (H), respectively.

Subsec. (c)(2)(G). Pub. L. 99–509, § 9335(f)(3), (5), redesignated former subpar. (D) as (G) and inserted ''and reporting to the Secretary on facilities and providers that are not providing appropriate medical care'' before the semicolon.

Subsec. (c)(2)(H). Pub. L. 99–509, § 9335(f)(4), (5), redesignated former subpar. (E) as (H) and inserted ''and encouraging participation in vocational rehabilitation programs'' after ''and transplantation''.

Subsec. (c)(3). Pub. L. 99–509, § 9335(g), inserted ''or to follow the recommendations of the medical review board'' after ''network plans and goals''.

Subsec. (c)(6). Pub. L. 99–509, § 9335(h), inserted ''and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment'' at end of first sentence.

Subsec. (c)(7). Pub. L. 99–509, § 9335(i)(1), added par. (7).

Subsec. (f)(7). Pub. L. 99–509, § 9335(k)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: ''The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program.''

1984—Subsecs. (a), (b)(1), (2)(A), (B), (3), (8). Pub. L. 98–369, § 2354(b)(41), substituted ''end stage'' for ''end-stage'' wherever appearing.

Subsec. (b)(11). Pub. L. 98–617 realigned margin of par. (11).

Pub. L. 98–369, § 2323(c), added par. (11).

Subsec. (c)(3). Pub. L. 98–369, § 2352(a), inserted provision that if the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

1983—Subsec. (b)(2)(A). Pub. L. 98–21 inserted ''or section 1395ww of this title (if applicable)'' after ''section 1395x(v) of this title''.

1981—Subsec. (b)(2)(B). Pub. L. 97–35, § 2145(a)(1), (2), substituted ''section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7)'' for ''section 1395x(v) of this title)'' and struck out provisions that such regulations provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services, and include a system for classifying comparable providers and facilities, and prospectively set rates or target rates with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services.

Subsec. (b)(3)(B). Pub. L. 97–35, § 2145(a)(3), substituted ''or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis)'' for ''or other basis''.

Subsec. (b)(4). Pub. L. 97–35, § 2145(a)(4), inserted reference to alternative basis of a method established under par. (7).

Subsec. (b)(6). Pub. L. 97–35, § 2145(a)(5), (6), substituted ''(except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent'' and ''any other procedure (including methods established under paragraph (7)) which the Secretary'' for ''shall such target rate exceed 70 percent'' and ''any other procedure which the Secretary'', respectively.

Subsec. (b)(7) to (10). Pub. L. 97–35, § 2145(a)(7), (8), added par. (7) and redesignated former pars. (7) to (9) as (8) to (10), respectively.

1980—Subsec. (e)(1). Pub. L. 96–499, § 957(a)(1)–(3), substituted ''services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish

equipment economically and efficiently,'' for ''services and renal dialysis facilities'' and ''such providers, facilities, and nonprofit entities'' for ''such providers and facilities''.

Subsec. (e)(2). Pub. L. 96–499, § 957(a)(4), substituted '', facility, or other entity will'' for ''or facility will''.

Subsec. (g). Pub. L. 96–499, § 957(b), substituted ''July'' for ''April'' in two places.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 applicable to erythropoietin furnished on or after Jan. 1, 1994, see section 13566(c) of Pub. L. 103–66, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4201(c)(2), Nov. 5, 1990, 104 Stat. 1388–104, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to erythropoietin furnished on or after January 1, 1991.''

Amendment by section 4201(d)(2) of Pub. L. 101–508 applicable to items and services furnished on or after July 1, 1991, see section 4201(d)(3)[(4)] of Pub. L. 101–508, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, § 6203(b)(3), Dec. 19, 1989, 103 Stat. 2235, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990.''

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4065(b) of Pub. L. 100–203 effective Jan. 1, 1988, see section 4065(c) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, § 9335(a)(3), Oct. 21, 1986, 100 Stat. 2029, provided that: ''The amendments made by paragraph (2) [amending this section] shall apply to applications filed on or after the date of the enactment of this Act [Oct. 21, 1986].''

Pub. L. 99–509, title IX, § 9335(j)(2), Oct. 21, 1986, 100 Stat. 2032, as amended by Pub. L. 100–203, title IV, § 4085(i)(21)(C), Dec. 22, 1987, 101 Stat. 1330–133, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to treatment furnished on or after January 1, 1987[,] except that, until network administrative organizations are established under section 1881(c)(1)(A) of the Social Security Act [42 U.S.C. 1395rr(c)(1)(A)] (as amended by subsection (d)(1) of this section), the distribution of payments described in the last sentence of section 1881(b)(7) of such Act shall be made based on the distribution of payments under section 1881 of such Act to network administrative organizations for fiscal year 1986.''

[Pub. L. 100–203, title IV, § 4085(i)(21), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment of section 9335(j)(2) of Pub. L. 99–509, set out above, by section 4085(i)(21)(C) of Pub. L. 100–203 is effective as if included in the enactment of Pub. L. 99–509.]

Pub. L. 99–509, title IX, § 9335(*l*), Oct. 21, 1986, 100 Stat. 2033, provided that: ''The amendments made by subsections (e), (f), and (g) [amending this section] shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1) [amending this section].''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2323(c) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395*l* of this title.

Pub. L. 98–369, div. B, title III, § 2352(b), July 18, 1984, 98 Stat. 1099, provided that: ''The amendment made by this section [amending this section] shall apply to determinations made by the Secretary on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(41) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, § 2145(b), Aug. 13, 1981, 95 Stat. 800, provided that: ''The amendments made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1981, and the Secretary of Health and Human Services shall first promulgate regulations to carry out section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] not later than October 1, 1981.''

EFFECTIVE DATE

Section effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as an Effective Date of 1978 Amendment note under section 426 of this title.

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, § 153(b)(4), July 15, 2008, 122 Stat. 2556, provided that: ''Nothing in this subsection [amending this section and sections 1395x and 1395y of this title and repealing provisions set out as a note under this section] or the amendments made by this subsection shall be construed as authorizing or requiring the Secretary of Health and Human Services to make payments under the payment system implemented under paragraph (14)(A)(i) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)), as added by paragraph (1), for any unrecovered amount for any bad debt attributable to deductible and coinsurance on items and services not included in the basic case-mix adjusted composite rate under paragraph (12) of such section as in effect before the date of the enactment of this Act [July 15, 2008].''

DRUG DESIGNATIONS

Pub. L. 113–93, title II, § 217(c), Apr. 1, 2014, 128 Stat. 1062, provided that: ''As part of the promulgation of annual rule for the Medicare end stage renal disease prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) for calendar year 2016, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish a process for—

''(1) determining when a product is no longer an oral-only drug; and

''(2) including new injectable and intravenous products into the bundled payment under such system.''

AUDITS OF COST REPORTS OF ESRD PROVIDERS AS RECOMMENDED BY MEDPAC

Pub. L. 113–93, title II, § 217(e), Apr. 1, 2014, 128 Stat. 1063, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct audits of Medicare cost reports beginning during 2012 for a representative sample of providers of services and renal dialysis facilities furnishing renal dialysis services.

''(2) FUNDING.—For purposes of carrying out paragraph (1), the Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account of $18,000,000 for fiscal year 2014. Amounts transferred under this paragraph for a fiscal year shall be available until expended.''

DELAY OF IMPLEMENTATION OF ORAL-ONLY ESRD-RELATED DRUGS IN THE ESRD PROSPECTIVE PAYMENT SYSTEM; MONITORING

Pub. L. 112–240, title VI, § 632(b), Jan. 2, 2013, 126 Stat. 2354, as amended by Pub. L. 113–93, title II, § 217(a), Apr. 1, 2014, 128 Stat. 1061; Pub. L. 113–295, div. B, title II, § 204, Dec. 19, 2014, 128 Stat. 4065, provided that:

''(1) DELAY.—The Secretary of Health and Human Services may not implement the policy under section 413.174(f)(6) of title 42, Code of Federal Regulations (relating to oral-only ESRD-related drugs in the ESRD prospective payment system), prior to January 1, 2025. Notwithstanding section 1881(b)(14)(A)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(A)(ii)), implementation of the policy described in the previous sentence shall be based on data from the most recent year available.

''(2) MONITORING.—With respect to the implementation of oral-only ESRD-related drugs in the ESRD prospective payment system under subsection (b)(14) of section 1881 of the Social Security Act (42 U.S.C. 1395rr(b)(14)), the Secretary of Health and Human Services shall monitor the bone and mineral metabolism of individuals with end stage renal disease.''

ANALYSIS OF CASE MIX PAYMENT ADJUSTMENTS

Pub. L. 112–240, title VI, § 632(c), Jan. 2, 2013, 126 Stat. 2354, provided that: ''By not later than January 1, 2016, the Secretary of Health and Human Services shall—

''(1) conduct an analysis of the case mix payment adjustments being used under section 1881(b)(14)(D)(i) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(D)(i)); and

''(2) make appropriate revisions to such case mix payment adjustments.''

INSPECTOR GENERAL STUDIES ON ESRD DRUGS

Pub. L. 108–173, title VI, § 623(c), Dec. 8, 2003, 117 Stat. 2312, provided that:

''(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct two studies with respect to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities.

''(2) STUDIES ON ESRD DRUGS.—

''(A) EXISTING DRUGS.—The first study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code exists prior to January 1, 2004.

''(B) NEW DRUGS.—The second study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code does not exist prior to January 1, 2004.

''(3) MATTERS STUDIED.—Under each study conducted under paragraph (1), the Inspector General shall—

''(A) determine the difference between the amount of payment made to end stage renal disease facilities under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for such drugs and biologicals and the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

''(B) estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

''(4) REPORTS.—

''(A) EXISTING ESRD DRUGS.—Not later than April 1, 2004, the Inspector General shall report to the Secretary [of Health and Human Services] on the study described in paragraph (2)(A).

''(B) NEW ESRD DRUGS.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).''

DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES

Pub. L. 108–173, title VI, § 623(e), Dec. 8, 2003, 117 Stat. 2315, which provided for establishment of a demonstration project, to be conducted for the 3-year period beginning on Jan. 1, 2006, of the use of a fully case-mix adjusted payment system for end stage renal disease services that bundled into payment rates amounts for drugs and biologicals (including erythropoietin) furnished to end stage renal disease patients under the medicare program which were separately billed by end stage renal disease facilities as of Dec. 8, 2003, and clinical laboratory tests related to such drugs and biologicals, and which authorized appropriations for the demonstration project, was repealed by Pub. L. 110–275, title I, § 153(b)(3)(C), July 15, 2008, 122 Stat. 2556.

REPORT ON A BUNDLED PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES

Pub. L. 108–173, title VI, § 623(f), Dec. 8, 2003, 117 Stat. 2316, provided that:

''(1) REPORT.—

''(A) IN GENERAL.—Not later than October 1, 2005, the Secretary [of Health and Human Services] shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. The report shall include a description of the methodology to be used for the establishment of payment rates, including components of the new system described in paragraph (2).

''(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

''(2) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include the following elements and features of a bundled prospective payment system:

''(A) BUNDLE OF ITEMS AND SERVICES.—A description of the bundle of items and services to be included under the prospective payment system.

''(B) CASE MIX.—A description of the case-mix adjustment to account for the relative resource use of different types of patients.

''(C) WAGE INDEX.—A description of an adjustment to account for geographic differences in wages.

''(D) RURAL AREAS.—The appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.

''(E) OTHER ADJUSTMENTS.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

''(F) UPDATE FRAMEWORK.—A methodology for appropriate updates under the prospective payment system.

''(G) ADDITIONAL RECOMMENDATIONS.—Such other matters as the Secretary determines to be appropriate.''

PROHIBITION ON EXCEPTIONS

Pub. L. 106–554, §1(a)(6) [title IV, §422(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, as amended by Pub. L. 108–173, title VI, §623(b)(1), Dec. 8, 2003 117 Stat. 2312, provided that:

''(A) IN GENERAL.—Subject to subparagraphs (B), (C), and (D), the Secretary of Health and Human Services may not provide for an exception under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) on or after December 31, 2000.

''(B) DEADLINE FOR NEW APPLICATIONS.—Subject to subparagraph (D), in the case of a facility that during 2000 did not file for an exception rate under such section, the facility may submit an application for an exception rate by not later than July 1, 2001.

''(C) PROTECTION OF APPROVED EXCEPTION RATES.—Any exception rate under such section in effect on December 31, 2000 (or, in the case of an application under subparagraph (B), as approved under such application) shall continue in effect so long as such rate is greater than the composite rate as updated by the amendment made by paragraph (1) [amending this section].

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''

DEVELOPMENT OF ESRD MARKET BASKET

Pub. L. 106–554, §1(a)(6) [title IV, §422(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, provided that:

''(1) DEVELOPMENT.—The Secretary of Health and Human Services shall collect data and develop an ESRD market basket whereby the Secretary can estimate, before the beginning of a year, the percentage by which the costs for the year of the mix of labor and nonlabor goods and services included in the ESRD composite rate under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) will exceed the costs of such mix of goods and services for the preceding year. In developing such index, the Secretary may take into account measures of changes in—

''(A) technology used in furnishing dialysis services;

''(B) the manner or method of furnishing dialysis services; and

''(C) the amounts by which the payments under such section for all services billed by a facility for a year exceed the aggregate allowable audited costs of such services for such facility for such year.

''(2) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the index developed under paragraph (1) no later than July 1, 2002, and shall include in the report recommendations on the appropriateness of an annual or periodic update mechanism for renal dialysis services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] based on such index.''

INCLUSION OF ADDITIONAL SERVICES IN COMPOSITE RATE

Pub. L. 106–554, §1(a)(6) [title IV, §422(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, provided that:

''(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a system which includes, to the maximum extent feasible, in the composite rate used for payment under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)), payment for clinical diagnostic laboratory tests and drugs (including drugs paid under section 1881(b)(11)(B) of such Act (42 U.S.C. 1395rr(b)(11)(B)) that are routinely used in furnishing dialysis services to medicare beneficiaries but which are currently separately billable by renal dialysis facilities.

''(2) REPORT.—The Secretary shall include, as part of the report submitted under subsection (b)(2) [set out above], a report on the system developed under paragraph (1) and recommendations on the appropriateness of incorporating the system into medicare payment for renal dialysis services.''

GAO STUDY ON ACCESS TO SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §422(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, directed the Comptroller General of the United States to study access of medicare beneficiaries to renal dialysis services and required the Comptroller General to submit to Congress a report on the study by not later than Jan. 1, 2003.

SPECIAL RULE FOR PAYMENT FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §422(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, provided that: ''Notwithstanding the amendment made by subsection (a)(1) [amending this section], for purposes of making payments under section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) for dialysis services furnished during 2001, the composite rate payment under paragraph (7) of such section—

''(1) for services furnished on or after January 1, 2001, and before April 1, 2001, shall be the composite rate payment determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for services furnished on or after April 1, 2001, and before January 1, 2002, shall be the composite rate payment (as determined taking into account the amendment made by subsection (a)(1)) increased by a transitional percentage allowance equal to 0.39 percent (to account for the timing of implementation of the CPI update).''

STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §222(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, required the Medicare Payment Advisory Commission to conduct a study on the appropriateness of a differential in payment level for home hemodialysis and to submit a report to Congress no later than 18 months after Nov. 29, 1999.

RENAL DIALYSIS-RELATED SERVICES

Pub. L. 105–33, title IV, §4558, Aug. 5, 1997, 111 Stat. 463, provided that:

''(a) AUDITING OF COST REPORTS.—Beginning with cost reports for 1996, the Secretary shall audit cost reports of each renal dialysis provider at least once every 3 years.

''(b) IMPLEMENTATION OF QUALITY STANDARDS.—The Secretary of Health and Human Services shall develop, by not later than January 1, 1999, and implement, by not later than January 1, 2000, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act [this subchapter].''

PROPAC STUDY ON ESRD COMPOSITE RATES

Pub. L. 101–508, title IV, §4201(b), Nov. 5, 1990, 104 Stat. 1388–102, provided that:

''(1) IN GENERAL.—

''(A) STUDY.—The Prospective Payment Assessment Commission (in this subsection referred to as the 'Commission') shall conduct a study to determine the

costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(B) RECOMMENDATIONS.—Based on information collected for the study described in subparagraph (A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

''(i) hemodialysis and other modalities of treatment,

''(ii) the appropriate services to be included in such payments,

''(iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,

''(iv) adjustments for labor and nonlabor costs,

''(v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,

''(vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and

''(vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

''(2) REPORT.—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

''(3) ANNUAL REPORT.—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.''

[Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.]

STAFF-ASSISTED HOME DIALYSIS DEMONSTRATION PROJECT

Pub. L. 101–508, title IV, § 4202, Nov. 5, 1990, 104 Stat. 1388–104, as amended by Pub. L. 103–432, title I, § 160(b), Oct. 31, 1994, 108 Stat. 4443, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services shall establish and carry out a 3-year demonstration project to determine whether the services of a home dialysis staff assistant providing services to a patient during hemodialysis treatment at the patient's home may be covered under the medicare program in a cost-effective manner that ensures patient safety.

''(2) NUMBER OF PARTICIPANTS.—The total number of eligible patients receiving services under the demonstration project established under paragraph (1) may not exceed 800.

''(b) PAYMENTS TO PARTICIPATING PROVIDERS AND FACILITIES.—

''(1) SERVICES FOR WHICH PAYMENT MAY BE MADE.—

''(A) IN GENERAL.—Under the demonstration project established under subsection (a), the Secretary shall make payments for 3 years under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to providers of services (other than a skilled nursing facility) or renal dialysis facilities for services of a qualified home hemodialysis staff assistant (as described in subsection (d)) provided to an individual described in subsection (c) during hemodialysis treatment at the individual's home in an amount determined under paragraph (2).

''(B) SERVICES DESCRIBED.—For purposes of subparagraph (A), the term 'services of a home hemodialysis staff assistant' means—

''(i) technical assistance with the operation of a hemodialysis machine in the patient's home and with such patient's care during in-home hemodialysis; and

''(ii) administration of medications within the patient's home to maintain the patency of the extra corporeal circuit.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Payment to a provider of services or renal dialysis facility participating in the demonstration project established under subsection (a) for the services described in paragraph (1) shall be prospectively determined by the Secretary, made on a per treatment basis, and shall be in an amount determined under subparagraph (B).

''(B) DETERMINATION OF PAYMENT AMOUNT.—(i) The amount of payment made under subparagraph (A) shall be the product of—

''(I) the rate determined under clause (ii) with respect to a provider of services or a renal dialysis facility; and

''(II) the factor by which the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] is adjusted for differences in area wage levels.

''(ii) The rate determined under this clause, with respect to a provider of services or renal dialysis facility, shall be equal to the difference between—

''(I) two-thirds of the labor portion of the composite rate applicable under section 1881(b)(7) of such Act to the provider or facility, and

''(II) the product of the national median hourly wage for a home hemodialysis staff assistant and the national median time expended in the provision of home hemodialysis staff assistant services (taking into account time expended in travel and predialysis patient care).

''(iii) For purposes of clause (ii)(II)—

''(I) the national median hourly wage for a home hemodialysis staff assistant and the national median average time expended for home hemodialysis staff assistant services shall be determined annually on the basis of the most recent data available, and

''(II) the national median hourly wage for a home hemodialysis staff assistant shall be the sum of 65 percent of the national median hourly wage for a licensed practical nurse and 35 percent of the national median hourly wage for a registered nurse.

''(C) PAYMENT AS ADD-ON TO COMPOSITE RATE.—The amount of payment determined under this paragraph shall be in addition to the amount of payment otherwise made to the provider of services or renal dialysis facility under section 1881(b) of such Act.

''(c) INDIVIDUALS ELIGIBLE TO RECEIVE SERVICES UNDER PROJECT.—

''(1) IN GENERAL.—An individual may receive services from a provider of services or renal dialysis facility participating in the demonstration project if—

''(A) the individual is not a resident of a nursing facility;

''(B) the individual is an end stage renal disease patient entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.];

''(C) the individual's physician certifies that the individual is confined to a bed or wheelchair and cannot transfer themselves [sic] from a bed to a chair;

''(D) the individual has a serious medical condition (as specified by the Secretary) which would be exacerbated by travel to and from a dialysis facility;

''(E) the individual is eligible for ambulance transportation to receive routine maintenance dialysis treatments, and, based on the individual's medical condition, there is reasonable expectation that such transportation will be used by the individual for a period of at least 6 consecutive months, such that the cost of ambulance transportation can reasonably be expected to meet or exceed the cost of home hemodialysis staff assistance as provided under subsection (b)(2); and

''(F) no family member or other individual is available to provide such assistance to the individual.

''(2) COVERAGE OF INDIVIDUALS CURRENTLY RECEIVING SERVICES.—Any individual who, on the date of the enactment of this Act [Nov. 5, 1990], is receiving staff assistance under the experimental authority provided under section 1881(f)(2) of the Social Security Act [42 U.S.C. 1395rr(f)(2)] shall be deemed to be an eligible individual for purposes of this subsection.

''(3) CONTINUATION OF COVERAGE UPON TERMINATION OF PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, any individual receiving services under the demonstration project established under subsection (a) as of the date of the termination of the project shall continue to be eligible for home hemodialysis staff assistance after such date under such title on the same terms and conditions as applied under the demonstration project.

''(d) QUALIFICATIONS FOR HOME HEMODIALYSIS STAFF ASSISTANTS.—For purposes of subsection (b), a home dialysis aide is qualified if the aide—

''(1) meets minimum qualifications as specified by the Secretary; and

''(2) meets any applicable qualifications as specified under the law of the State in which the home hemodialysis staff assistant is providing services.

''(e) REPORTS.—

''(1) INTERIM STATUS REPORT.—Not later than December 1, 1992, the Secretary shall submit to Congress a preliminary report on the status of the demonstration project established under subsection (a).

''(2) FINAL REPORT.—Not later than December 31, 1995, the Secretary shall submit to Congress a final report evaluating the project, and shall include in such report recommendations regarding appropriate eligibility criteria and cost-control mechanisms for medicare coverage of the services of a home dialysis aide providing medical assistance to a patient during hemodialysis treatment at the patient's home.

''(f) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of the Social Security Act [42 U.S.C. 1395t]) of not more than the following amounts to carry out the demonstration project established under subsection (a) (without regard to amounts appropriated in advance in appropriation Acts):

''(1) For fiscal year 1991, $4,000,000.

''(2) For fiscal year 1992, $4,000,000.

''(3) For fiscal year 1993, $3,000,000.

''(4) For fiscal year 1994, $2,000,000.

''(5) For fiscal year 1995, $1,000,000.''

STUDIES OF END-STAGE RENAL DISEASE PROGRAM

Pub. L. 100–203, title IV, §4036(d)(1)–(4), Dec. 22, 1987, 101 Stat. 1330–79, provided that:

''(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall arrange for a study of the end-stage renal disease program within the medicare program.

''(2) Among other items, the study shall address—

''(A) access to treatment by both individuals eligible for medicare benefits and those not eligible for such benefits;

''(B) the quality of care provided to end-stage renal disease beneficiaries, as measured by clinical indicators, functional status of patients, and patient satisfaction;

''(C) the effect of reimbursement on quality of treatment;

''(D) major epidemiological and demographic changes in the end-stage renal disease population that may affect access to treatment, the quality of care, or the resource requirements of the program; and

''(E) the adequacy of existing data systems to monitor these matters on a continuing basis.

''(3) The Secretary shall submit to Congress, not later than 3 years after the date of the enactment of this Act [Dec. 22, 1987], a report on the study.

''(4) The Secretary shall request the National Academy of Sciences, acting through the Institute of Medicine, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.''

RATES FOR DIALYSIS SERVICES

Pub. L. 99–509, title IX, §9335(a)(1), Oct. 21, 1986, 100 Stat. 2029, as amended by Pub. L. 101–239, title VI, §6203(a)(1), Dec. 19, 1989, 103 Stat. 2235; Pub. L. 101–508, title IV, §4201(a), Nov. 5, 1990, 104 Stat. 1388–102; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §222(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that: ''Effective with respect to dialysis services provided on or after October 1, 1986, and before December 31, 1990, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00. With respect to services furnished on or after January 1, 1991, and before January 1, 2000, such base rate shall be equal to the respective rate in effect as of September 30, 1990 (determined without regard to any reductions imposed pursuant to section 6201 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, set out as a note under section 904 of Title 2, The Congress]), increased by $1.00. No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1) of such Act [42 U.S.C. 1395rr(b)(1)].''

[Pub. L. 101–239, title VI, §6203(a)(2), Dec. 19, 1989, 103 Stat. 2235, provided that: ''The amendment made by paragraph (1) [amending section 9335(a)(1) of Pub. L. 99–509, set out above] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].'']

STUDY AND REPORT ON MEDICARE PAYMENT RATE REDUCTIONS FOR PATIENTS WITH END STAGE RENAL DISEASE

Pub. L. 99–509, title IX, §9335(b), Oct. 21, 1986, 100 Stat. 2029, directed Secretary of Health and Human Services

to provide for a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and a report to Congress on results of the study by not later than Jan. 1, 1988, with Secretary to enter into an appropriate arrangement with the National Academy of Sciences or other appropriate nonprofit private entity for the conduct of the study.

DEADLINE FOR ESTABLISHING NEW END STAGE RENAL DISEASE NETWORK AREAS; TRANSITION

Pub. L. 99–509, title IX, § 9335(d)(2), (3), Oct. 21, 1986, 100 Stat. 2031, as amended by Pub. L. 100–203, title IV, § 4009(j)(6)(E), Dec. 22, 1987, 101 Stat. 1330–59, provided that:

''(2) DEADLINE FOR ESTABLISHING NEW AREAS.—The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1) [amending this section], not later than May 1, 1987. The Secretary shall designate network administrative organizations for such areas by not later than July 1, 1987.

''(3) TRANSITION.—If, under the amendment made by paragraph (1), the Secretary designates a network administrative organization for an area which was not previously designated for that area, the Secretary shall offer to continue to fund the previously designated organization for that area for a period of 30 days after the first date the newly designated organization assumes the duties of a network administrative organization for that area.''

REPORT ON ESTABLISHMENT OF NATIONAL END STAGE RENAL DISEASE REGISTRY

Pub. L. 99–509, title IX, § 9335(i)(2), Oct. 21, 1986, 100 Stat. 2032, provided that: ''The Secretary of Health and Human Services shall submit to the Congress, no later than April 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) [amending this section] and shall establish such registry by not later than January 1, 1988.''

DEADLINE FOR ESTABLISHMENT OF PROTOCOLS ON REUSE OF DIALYZER FILTERS

Pub. L. 99–509, title IX, § 9335(k)(2), Oct. 21, 1986, 100 Stat. 2033, as amended by Pub. L. 100–203, title IV, § 4036(c)(1)(A), Dec. 22, 1987, 101 Stat. 1330–79, provided that: ''The Secretary of Health and Human Services shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act [42 U.S.C. 1395rr(f)(7)(A)] by not later than October 1, 1987 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines).''

[Pub. L. 100–203, title IV, § 4036(c)(1)(B), Dec. 22, 1987, 101 Stat. 1330–79, provided that: ''The amendment made by subparagraph (A) [amending section 9335(k)(2) of Pub. L. 99–509, set out above] shall be effective as if included in the enactment of section 9335(k)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''']

LIMITATION ON MERGER OF END STAGE RENAL DISEASE NETWORKS

Pub. L. 99–272, title IX, § 9214, Apr. 7, 1986, 100 Stat. 180, provided that: ''The Secretary of Health and Human Services shall maintain renal disease network organizations as authorized under section 1881(c) of the Social Security Act [42 U.S.C. 1395rr(c)], and may not merge the network organizations into other organizations or entities. The Secretary may consolidate such network organizations, but only if such consolidation does not result in fewer than 14 such organizations being permitted to exist.''

§ 1395rr–1. Medicare coverage for individuals exposed to environmental health hazards

(a) Deeming of individuals as eligible for medicare benefits

(1) In general

For purposes of eligibility for benefits under this subchapter, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 426(a) of this title.

(2) Discretionary deeming

For purposes of eligibility for benefits under this subchapter, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 426(a) of this title.

(3) Effective date of coverage

An Individual[1] who is deemed eligible for benefits under this subchapter under paragraph (1) or (2) shall be—

(A) entitled to benefits under the program under Part[1] A as of the date of such deeming; and

(B) eligible to enroll in the program under Part[1] B beginning with the month in which such deeming occurs.

(b) Pilot program for care of certain individuals residing in emergency declaration areas

(1) Program; purpose

(A) Primary pilot program

The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this subchapter to individuals described in paragraph (2)(A).

(B) Optional pilot programs

The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

(2) Individual described

For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

(B) is an environmental exposure affected individual described in subsection (e)(3) who—

[1] So in original. Probably should not be capitalized.

(i) is deemed under subsection (a)(2); and

(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

(3) Flexible benefits and services

A pilot program under this subsection may provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this subchapter, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

(4) Innovative reimbursement methodologies

For purposes of the pilot program under this subsection, the Secretary—

(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this subchapter, if such benefits, items, or services are furnished pursuant to paragraph (3); and

(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

(5) Limitation

Consistent with section 1395y(b) of this title, no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

(6) Waiver authority

The Secretary may waive such provisions of this subchapter and subchapter XI as are necessary to carry out pilot programs under this subsection.

(7) Funding

For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

(8) Waiver of budget neutrality

The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this subchapter.

(c) Determinations

(1) By the Commissioner of Social Security

For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 401(g) of this title, shall determine whether individuals are environmental exposure affected individuals.

(2) By the Secretary

The Secretary shall determine eligibility for pilot programs under subsection (b).

(d) Emergency declaration defined

For purposes of this section, the term ''emergency declaration'' means a declaration of a public health emergency under section 9604(a) of this title.

(e) Environmental exposure affected individual defined

(1) In general

For purposes of this section, the term ''environmental exposure affected individual'' means—

(A) an individual described in paragraph (2); and

(B) an individual described in paragraph (3).

(2) Individual described

(A) In general

An individual described in this paragraph is any individual who—

(i) is diagnosed with 1 or more conditions described in subparagraph (B);

(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

(I) not less than 10 years prior to such diagnosis; and

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

(iii) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and

(iv) is determined under this section to meet the criteria in this subparagraph.

(B) Conditions described

For purposes of subparagraph (A), the following conditions are described in this subparagraph:

(i) Asbestosis, pleural thickening, or pleural plaques as established by—

(I) interpretation by a ''B Reader'' qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach,

esophagus, pharynx, or ovary, as established by—

(I) pathologic examination of biopsy tissue;

(II) cytology from bronchioalveolar lavage; or

(III) such other diagnostic standards as the Secretary specifies.

(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

(3) Other individual described

An individual described in this paragraph is any individual who—

(A) is not an individual described in paragraph (2);

(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

(D) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this paragraph.

(Aug. 14, 1935, ch. 531, title XVIII, § 1881A, as added Pub. L. 111–148, title X, § 10323(a), Mar. 23, 2010, 124 Stat. 954.)

Editorial Notes

REFERENCES IN TEXT

Parts A and B, referred to in subsecs. (a)(3) and (b)(2), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

§ 1395ss. Certification of medicare supplemental health insurance policies

(a) Submission of policy by insurer

(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3), (m), and (n), such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulation or 1991 Federal Regulation (as the case may be)) by the date specified in subsection (p)(1)(C); or

(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, on and after the effective date specified in subsection (p)(1)(C), in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(b) Standards and requirements; periodic review by Secretary

(1) Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that—

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of

benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t),

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). Each report required under subparagraph (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards and requirements of this paragraph, actions taken by the State to bring such policies into compliance, information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.

(c) Requisite findings

The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (s), the issuer of the policy)—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t));

(2) meets the requirements of subsection (r);

(3)(A) accepts a notice under section 1395u(h)(3)(B) of this title as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received—

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1395u(h)(3)(B) of this title with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (*o*) through (t).

(d) Criminal penalties; civil penalties for certain violations

(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in

regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this subchapter, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this subchapter (including an individual electing a Medicare+Choice plan under section 1395w–21 of this title)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this subchapter or subchapter XIX,

(II) in the case of an individual not electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(ii) Whoever violates clause (i) shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i)(II) with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to ''duplicate'' any health benefits under this subchapter, under subchapter XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to ''duplicate'' health benefits under this subchapter or under another health insurance policy if it—

(I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,

(II) coordinates against or excludes items and services available or paid for under this subchapter or under another health insurance policy, and

(III) for policies sold or issued on or after the end of the 90-day period beginning on August 21, 1996, discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms ''coordinates'' and ''coordination'' mean, with respect to a policy in relation to health benefits under this subchapter or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this subchapter or under another health insurance policy.

(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this subchapter who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be furnished as a part of (or together with) the application for such policy.

(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such violation.

(III) A policy described in this subclause (to which subclauses (I) and (II) do not apply) is a Medicare supplemental policy, a policy described in clause (v), or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (m)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before August 21, 1996) for that type of policy, as revised as follows:

(I) In each statement, amend the second line to read as follows:

"THIS IS NOT MEDICARE SUPPLEMENT INSURANCE".

(II) In each statement, strike the third line and insert the following: ''**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**''.

(III) In each statement not described in subclause (V), strike the boldface matter that begins ''**This insurance**'' and all that follows up to the next paragraph that begins ''**Medicare**''.

(IV) In each statement not described in subclause (V), insert before the boxed matter (that states ''**Before You Buy This Insurance**'') the following: ''**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**''.

(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins ''Federal law'' to read as follows: ''Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.''.

(viii)(I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State's ability to regulate health insurance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A or enrolled under part B ''duplicates'' health benefits under this subchapter or under a Medicare supplemental policy.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (ii), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies (including any Medicare+Choice plan) the individual has, from what source, and whether the individual is entitled to any medical assistance under subchapter XIX, whether as a qualified medicare beneficiary or otherwise, and

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that—

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals may be eligible for benefits under the State medicaid program under subchapter XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such subchapter and may be reinstituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under subchapter XIX, the sale of a medicare supplemental policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has a medicare supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer's or seller's knowledge, duplicate coverage (taking into account any such replacement).

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under subchapter XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such subchapter pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1396d(p)(1) of this title, the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title.

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under

title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed.

(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).

(5) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1320a–7a(a) of this title.

(e) Dissemination of information

(1) The Secretary shall provide to all individuals entitled to benefits under this subchapter (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this subchapter.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f) Study and evaluation of comparative effectiveness of various State approaches to regulating medicare supplemental policies; report to Congress no later than January 1, 1982; periodic evaluations

(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this subchapter (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this subchapter.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this subchapter of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under subchapter XIX to such policies).

(g) Definitions

(1) For purposes of this section, a medicare supplemental policy is a health insurance policy

or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include a prescription drug plan under part D or a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1395*l*(a)(1)(A) of this title. For purposes of this section, the term ''policy'' includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term ''NAIC Model Standards'' means the ''NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act'', adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplemental policies.

(B) The term ''State with an approved regulatory program'' means a State for which the Secretary has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) Rules and regulations

The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

(i) Commencement of certification program

(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) State regulation of policies issued in other States

Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k) Amended NAIC Model Regulation or Federal model standards applicable; effective date; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on July 1, 1988, the National Association of Insurance Commissioners (in this subsection referred to as the ''Association'') amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, except as provided in subsection (m), subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (*l*) referred to as the ''amended NAIC Model Regulation'').

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l)[1] referred to as ''Federal model standards'') for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (*l*), (m), and (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(*l*) Transitional compliance with NAIC Model Transition Regulation; "qualifying medicare supplemental policy" and "NAIC Model Transition Regulation" defined

(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term ''qualifying medicare supplemental policy'' means a medicare supplemental policy—

(A) issued in a State which—

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of—

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this subchapter and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

(A) the improved benefits under this subchapter contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term ''NAIC Model Transition Regulation'' refers to the standards contained in the ''Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions'' (as adopted by the National Association of Insurance Commissioners in September 1987).

[1] So in original. Probably should be ''subsection (*l*)''.

(m) Revision of amended NAIC Model Regulation and amended Federal model standards; effective dates; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on December 13, 1989, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the ''Association'') revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the ''revised NAIC Model Regulation'').

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as ''revised Federal model standards'') for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(n) Transition compliance with revision of NAIC Model Regulation and Federal model standards

(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term ''transition deadline'' means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is—

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this subchapter made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term ''qualifying medicare supplemental policy'' means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before December 13, 1989.

(4)(A) The date specified in this paragraph for a policy issued in a State is—

(i) the first date a State adopts, after December 13, 1989, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B),

whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this subchapter and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

(A) the changes in benefits under this subchapter effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before December 13, 1989, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of December 13, 1989, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(*o*) Requirements of group benefits; core group benefits; uniform outline of coverage

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsections (p), (v)[2] (w), and (y).

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(4) The issuer of the medicare supplemental policy complies with subsection (s)(2)(E) and subsection (x).

(5) In addition to the requirement under paragraph (2), the issuer of the policy must make available to the individual at least Medicare supplemental policies with benefit packages classified as ''C'' or ''F''.

(p) Standards for group benefits

(1)(A) If, within 9 months after November 5, 1990, the National Association of Insurance Commissioners (in this subsection referred to as the ''Association'') changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate—

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ''1991 NAIC Model Regulation'').

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the ''1991 Federal Regulation'').

[2] So in original. Probably should be followed by a comma.

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC Model Regulation or 1991 Federal Regulation, but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this subchapter are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide—

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies; and

(C) that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 plans described in paragraph (11)(A).

(3) The benefits under paragraph (2) shall, to the extent possible—

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of November 5, 1990; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A)(i) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards described in clauses (i) through (iii) of paragraph (1)(A) in those States that on November 5, 1990, had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholders or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (*o*) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provi-

sions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 1991 NAIC Model Regulation or 1991 Federal Regulation under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

(i) The benefit package classified as ''F'' under the standards established by such paragraph, except that it has a high deductible feature.

(ii) The benefit package classified as ''J'' under the standards established by such paragraph, except that it has a high deductible feature.

(B) For purposes of subparagraph (A), a high deductible feature is one which—

(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

(C) The amount specified in this subparagraph—

(i) for 1998 and 1999 is $1,500, and

(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year.

If any amount determined under clause (ii) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(q) Guaranteed renewal of policies; termination; suspension

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and—

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets[3] the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, issuer[4] of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under subchapter XIX, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection

[3] So in original. Probably should be ''meet''.

[4] So in original. Probably should be preceded by ''the''.

(n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under subchapter XIX, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such subchapter.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph or paragraph (6) is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 426(b) of this title and is covered under a group health plan (as defined in section 1395y(b)(1)(A)(v) of this title). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstituted (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.

(r) Required ratio of aggregate benefits to aggregate premiums

(1) A medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C)) in any State unless—

(A) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A), treating policies of the same type as a single policy for each standard package.

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a calendar year, not later than the third quarter of the succeeding calendar year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

(4) The Secretary shall submit in October of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disallowance of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss ratios). Such report shall include a list of the policies that failed to comply with such loss ratio requirements or other requirements of this section.

(5) The Secretary may perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved.

(6)(A) A person who fails to provide refunds or credits as required in paragraph (1)(B) is subject to a civil money penalty of not to exceed $25,000

for each policy issued for which such failure occurred. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificate holder for credits required under such paragraph.

(s) Coverage for pre-existing conditions

(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B.

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c)[5] of the Public Health Service Act) of—

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any pre-existing condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.

(E) An issuer of a medicare supplemental policy shall not deny or condition the issuance or effectiveness of the policy (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) and shall not discriminate in the pricing of the policy (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(F) RULE OF CONSTRUCTION.—Nothing in subparagraph (E) or in subparagraphs (A) or (B) of subsection (x)(2) shall be construed to limit the ability of an issuer of a medicare supplemental policy from, to the extent otherwise permitted under this subchapter—

(i) denying or conditioning the issuance or effectiveness of the policy or increasing the premium for an employer based on the manifestation of a disease or disorder of an individual who is covered under the policy; or

(ii) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer).

(3)(A) The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a preexisting condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the period specified in subparagraph (E) and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this subchapter and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1395w–21(e)(4) of this title or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, and there are circumstances that would permit the dis-

[5] See References in Text note below.

continuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan.

(iii) The individual is enrolled with an eligible organization under a contract under section 1395mm of this title, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1395*l*(a)(1)(A) of this title, or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1395w–21(e)(4) of this title and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

(v) The individual—

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C, any eligible organization under a contract under section 1395mm of this title, any similar organization operating under demonstration project authority, any PACE provider under section 1395eee of this title, or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1395w–21(e) of this title).

(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under part C or in a PACE program under section 1395eee of this title, and disenrolls from such plan or such program by not later than 12 months after the effective date of such enrollment.

(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as ''A'', ''B'', ''C'', or ''F'' under the standards established under subsection (p)(2).

(ii)(I) Subject to subclause (II), only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

(II) If the medicare supplemental policy referred to in subparagraph (B)(v) was a medigap Rx policy (as defined in subsection (v)(6)(A)), a medicare supplemental policy described in this subparagraph is such policy in which the individual was most recently enrolled as modified under subsection (v)(2)(C)(i) or, at the election of the individual, a policy referred to in subsection (v)(3)(A)(i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi) and subject to subsection (v)(1), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.

(F)(i) Subject to clause (ii), for purposes of this paragraph—

(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of this subsection is subject to a civil money penalty of not to exceed $5,000 for each such failure. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(t) Medicare select policies

(1) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

the issuer is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to indi-

viduals entitled to benefits under this subchapter and under that policy) are not allowable under section 1395y(a)(1) of this title. Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E)[5] of section 1395u(b) of this title shall apply to the entity.

(u) Additional rules relating to individuals enrolled in MSA plans and in private fee-for-service plans

(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1395w–21 of this title an election of an MSA plan or a Medicare+Choice private fee-for-service plan.

(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

(B) A policy described in this subparagraph is any of the following:

(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(ii) A policy of insurance to which substantially all of the coverage relates to—

(I) liabilities incurred under workers' compensation laws,

(II) tort liabilities,

(III) liabilities relating to ownership or use of property, or

(IV) such other similar liabilities as the Secretary may specify by regulations.

(iii) A policy of insurance that provides coverage for a specified disease or illness.

(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.

(v) Rules relating to medigap policies that provide prescription drug coverage

(1) Prohibition on sale, issuance, and renewal of new policies that provide prescription drug coverage

(A) In general

Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

(B) Continuation permitted for non-part D enrollees

Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

(C) Construction

Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of ''H'', ''I'', and ''J'' policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

(2) Elimination of duplicative coverage upon part D enrollment

(A) In general

In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

(i) before the end of the initial part D enrollment period, the individual may—

(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

(II) continue the policy in effect subject to the modification described in subparagraph (C)(i); or

(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

(B) Notice required to be provided to current policyholders with medigap Rx policy

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1395w–101(b)(2)(A) of this title, the individual has the option of—

(I) continuing enrollment in the individual's current plan, but the plan's coverage of prescription drugs will be modified under subparagraph (C)(i); or

(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual's current plan without change, but—

(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

(II) if the current plan does not provide creditable prescription drug coverage (as defined in section 1395w–113(b)(4) of this title), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under a part D plan and any such enrollment is subject to a late enrollment penalty.

(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

(C) Modification

(i) In general

The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual's coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

(ii) Continuation of renewability and application of modification

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

(D) References to Rx policies

(i) H, I, and J policies

Any reference to a benefit package classified as ''H'', ''I'', or ''J'' (including the benefit package classified as ''J'' with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages as modified shall not be counted as a separate benefit package under such subsection.

(ii) Application in waivered States

Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

(3) Availability of substitute policies with guaranteed issue

(A) In general

The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', or ''F'' (including the benefit package classified as ''F'' with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in subparagraph (A) or (B) of subsection (w)(2) and that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the effective date of the individual's coverage under a part D plan.

(B) Individual covered

An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

(i) enrolls in a part D plan during the initial part D enrollment period;

(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

(C) Special rule for waivered States

For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

(4) Enforcement

(A) Penalties for duplication

The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

(B) Guaranteed issue

The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

(5) Construction

Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met with respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

(6) Definitions

For purposes of this subsection:

(A) Medigap Rx policy

The term ''medigap Rx policy'' means a medicare supplemental policy—

(i) which has a benefit package classified as ''H'', ''I'', or ''J'' (including the benefit package classified as ''J'' with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

(ii) to which such standards do not apply (or to which such standards have been

waived under subsection (p)(6)) but which provides benefits for prescription drugs.

Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).

(B) Part D enrollee

The term ''part D enrollee'' means an individual who is enrolled in a part D plan.

(C) Part D plan

The term ''part D plan'' means a prescription drug plan or an MA–PD plan (as defined for purposes of part D).

(D) Initial part D enrollment period

The term ''initial part D enrollment period'' means the initial enrollment period described in section 1395w–101(b)(2)(A) of this title.

(w) Development of new standards for medicare supplemental policies

(1) In general

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ''1991 NAIC Model Regulation'' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to ''date of enactment of this subsection'' deemed a reference to December 8, 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

(2) New benefit packages

The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

(A) First new benefit package

A benefit package consisting of the following:

(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

(iii) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2006 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) Second new benefit package

A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

(i) Substitute ''75 percent'' for ''50 percent'' in clause (i) of such subparagraph.

(ii) Substitute ''$2,000'' for ''$4,000'' in clause (iii) of such subparagraph.

(x) Limitations on genetic testing and information

(1) Genetic testing

(A) Limitation on requesting or requiring genetic testing

An issuer of a medicare supplemental policy shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) Rule of construction

Subparagraph (A) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(C) Rule of construction regarding payment

(i) In general

Nothing in subparagraph (A) shall be construed to preclude an issuer of a medicare supplemental policy from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of subchapter XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (s)(2)(E).

(ii) Limitation

For purposes of clause (i), an issuer of a medicare supplemental policy may request only the minimum amount of information necessary to accomplish the intended purpose.

(D) Research exception

Notwithstanding subparagraph (A), an issuer of a medicare supplemental policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(i) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(ii) The issuer clearly indicates to each individual, or in the case of a minor child,

to the legal guardian of such child, to whom the request is made that—

(I) compliance with the request is voluntary; and

(II) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(iii) No genetic information collected or acquired under this subparagraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rating, or the creation, renewal, or replacement of a plan, contract, or coverage for health insurance or health benefits.

(iv) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subparagraph, including a description of the activities conducted.

(v) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subparagraph.

(2) Prohibition on collection of genetic information

(A) In general

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information for underwriting purposes (as defined in paragraph (3)).

(B) Prohibition on collection of genetic information prior to enrollment

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(C) Incidental collection

If an issuer of a medicare supplemental policy obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subparagraph (B) if such request, requirement, or purchase is not in violation of subparagraph (A).

(3) Definitions

In this subsection:

(A) Family member

The term ''family member'' means with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(B) Genetic information

(i) In general

The term ''genetic information'' means, with respect to any individual, information about—

(I) such individual's genetic tests,

(II) the genetic tests of family members of such individual, and

(III) subject to clause (iv), the manifestation of a disease or disorder in family members of such individual.

(ii) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(iii) Exclusions

The term ''genetic information'' shall not include information about the sex or age of any individual.

(C) Genetic test

(i) In general

The term ''genetic test'' means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(ii) Exceptions

The term ''genetic test'' does not mean—

(I) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(II) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(D) Genetic services

The term ''genetic services'' means—

(i) a genetic test;

(ii) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(iii) genetic education.

(E) Underwriting purposes

The term ''underwriting purposes'' means, with respect to a medicare supplemental policy—

(i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) the computation of premium or contribution amounts under the policy;

(iii) the application of any pre-existing condition exclusion under the policy; and

(iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(F) Issuer of a medicare supplemental policy

The term ''issuer of a medicare supplemental policy'' includes a third-party administrator or other person acting for or on behalf of such issuer.

(4) Genetic information of a fetus or embryo

Any reference in this section to genetic information concerning an individual or family member of an individual shall—

(A) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(B) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(y) Development of new standards for certain medicare supplemental policies

(1) In general

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ''1991 NAIC Model Regulation'' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to ''date of enactment of this subsection'' deemed a reference to March 23, 2010. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

(2) Benefit packages described

The benefit packages described in this paragraph are benefit packages classified as ''C'' and ''F''.

(z) Limitation on certain medigap policies for newly eligible Medicare beneficiaries

(1) In general

Notwithstanding any other provision of this section, on or after January 1, 2020, a medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

(2) Newly eligible Medicare beneficiary defined

In this subsection, the term ''newly eligible Medicare beneficiary'' means an individual who is neither of the following:

(A) An individual who has attained age 65 before January 1, 2020.

(B) An individual who was entitled to benefits under part A pursuant to section 426(b) or 426–1 of this title, or deemed to be eligible for benefits under section 426(a) of this title, before January 1, 2020.

(3) Treatment of waivered States

In the case of a State described in subsection (p)(6), nothing in this section shall be construed as preventing the State from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

(4) Treatment of references to certain policies

In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as ''C'' or ''F'' shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as ''D'' or ''G'', respectively.

(5) Enforcement

The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.

(Aug. 14, 1935, ch. 531, title XVIII, § 1882, as added Pub. L. 96–265, title V, § 507(a), June 9, 1980, 94 Stat. 476; amended H. Res. 549, Mar. 25, 1980; Pub. L. 100–93, § 13, Aug. 18, 1987, 101 Stat. 697; Pub. L. 100–203, title IV, § 4081(b), Dec. 22, 1987, 101 Stat. 1330–127; Pub. L. 100–360, title II, § 221(a)–(f), title IV, §§ 411(i)(1)(B), (C), 428(b), July 1, 1988, 102 Stat. 742–746, 788, 817; Pub. L. 101–234, title II, § 203(a)(1), Dec. 13, 1989, 103 Stat. 1982; Pub. L. 101–508, title IV, §§ 4207(k)(1), formerly 4027(k)(1), 4351, formerly 4351(a), 4352, 4353(a)–(d)(1), 4354(a), (b), 4355(a)–(c), 4356(a), 4357(a), 4358(a), (b)(1), (2), Nov. 5, 1990, 104 Stat. 1388–124, 1388–125, 1388–129, 1388–130, 1388–132, 1388–134 to 1388–137; Pub. L. 103–432, title I, §§ 160(d)(4), 171(a)–(d)(3)(B), (4), (e)(1), (2), (f)(1), (g), (h)(1), (j)(2), (k), Oct. 31, 1994, 108 Stat. 4444–4451; Pub. L. 104–191, title II, § 271(a), (b), Aug. 21, 1996, 110 Stat. 2034–2036; Pub. L. 105–33, title IV, §§ 4002(j)(2), 4003, 4031(a)–(c), 4032(a), Aug. 5, 1997, 111 Stat. 330, 355, 357, 359; Pub. L. 105–362, title VI, § 601(b)(6), Nov. 10, 1998, 112 Stat. 3286; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(k)(13), (14), title V, §§ 501(a)(2), 536(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368, 1501A–378, 1501A–390; Pub. L. 106–170, title II, § 205(a), Dec. 17, 1999, 113 Stat. 1899; Pub. L. 106–554, § 1(a)(6) [title VI, § 618], Dec. 21, 2000, 114 Stat. 2763, 2763A–562; Pub. L. 108–173, title I, § 104(a), (b), title VII, § 736(e), Dec. 8, 2003, 117 Stat. 2161, 2164, 2357; Pub. L. 110–161, div. H, title I, § 1502(f), Dec. 26, 2007, 121 Stat. 2250; Pub. L. 110–233, title I, § 104(a), (b), May 21, 2008, 122 Stat. 899, 900; Pub. L. 110–275, title I, § 104(b), July 15, 2008, 122 Stat. 2502; Pub. L. 111–148, title III, § 3210, Mar. 23, 2010, 124 Stat. 460; Pub. L. 114–10, title IV, § 401, Apr. 16, 2015, 129 Stat. 159.)

Editorial Notes

REFERENCES IN TEXT

Section 171(m) of the Social Security Act Amendments of 1994, referred to in subsecs. (d)(3)(A)(vi)(IV) and (r)(1), (2)(A), is section 171(m) of Pub. L. 103–432, title I, Oct. 31, 1994, 108 Stat. 4452, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (g)(1), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code, and was repealed by Pub. L. 105–33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 2355 of the Deficit Reduction Act of 1984, referred to in subsec. (g)(1), is section 2355 of Pub. L.

98–369, div. B, title III, July 18, 1984, 98 Stat. 1103, which is not classified to the Code.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (g)(1), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code, and was repealed by Pub. L. 105–33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

The Medicare Catastrophic Coverage Act of 1988, referred to in subsecs. (k)(1)(A), (2)(A) and (*l*)(4)(A), is Pub. L. 100–360, July 1, 1988, 102 Stat. 683, as amended. For complete classification of this Act to the Code, see Short Title of 1988 Amendment note set out under section 1305 of this title and Tables.

The Medicare Catastrophic Coverage Repeal Act of 1989, referred to in subsecs. (m)(1)(A), (2)(A) and (n)(2)(A), (5)(A), is Pub. L. 101–234, Dec. 13, 1989, 103 Stat. 1979. For complete classification of this Act to the Code, see Short Title of 1989 Amendment note set out under section 1305 of this title and Tables.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (p)(1)(A)(iv), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (s)(2)(D), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Paragraphs (2)(A), (B) and (3)(C)–(E) of section 1395u(b) of this title, referred to in subsec. (t)(3), were repealed by Pub. L. 108–173, title IX, § 911(c)(3)(B)(i), (C)(iv), Dec. 8, 2003, 117 Stat. 2384.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (w)(1), is Pub. L. 108–173, Dec. 8, 2003, 117 Stat. 2066. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (x)(1)(C)(i), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

AMENDMENTS

2015—Subsec. (z). Pub. L. 114–10 added subsec. (z).

2010—Subsec. (*o*)(1). Pub. L. 111–148, § 3210(b), substituted ''(w), and (y)'' for '', and (w)''.

Subsec. (y). Pub. L. 111–148, § 3210(a), added subsec. (y).

2008—Subsec. (*o*)(4). Pub. L. 110–233, § 104(b)(3), added par. (4).

Subsec. (*o*)(5). Pub. L. 110–275 added par. (5).

Subsec. (s)(2)(E), (F). Pub. L. 110–233, § 104(a), added subpars. (E) and (F).

Subsec. (x). Pub. L. 110–233, § 104(b)(1), added subsec. (x).

Subsec. (x)(4). Pub. L. 110–233, § 104(b)(2), added par. (4).

2007—Subsec. (r)(5). Pub. L. 110–161 substituted ''The Secretary may'' for ''(A) The Comptroller General shall periodically, not less often than once every 3 years,'' and struck out ''and to the Secretary'' after ''State involved'' and subpar. (B) which read as follows: ''The Secretary may independently perform such compliance audits.''

2003—Subsec. (d)(3)(A)(i)(II). Pub. L. 108–173, § 736(e)(1), substituted ''plan, a medicare supplemental policy'' for ''plan a medicare supplemental policy''.

Subsec. (d)(3)(B)(iii)(II). Pub. L. 108–173, § 736(e)(2), substituted ''to the best of the issuer's or seller's knowledge'' for ''to the best of the issuer or seller's knowledge''.

Subsec. (g)(1). Pub. L. 108–173, § 104(b)(2)(A), inserted ''a prescription drug plan under part D or'' after ''but does not include''.

Subsec. (g)(2)(A). Pub. L. 108–173, § 736(e)(3), substituted ''medicare supplemental policies'' for ''medicare supplement policies''.

Subsec. (*o*)(1). Pub. L. 108–173, § 104(b)(2)(B), substituted ''subsections (p), (v), and (w)'' for ''subsection (p)''.

Subsec. (p)(2)(B). Pub. L. 108–173, § 736(e)(4), substituted ''; and'' for '', and'' at end.

Subsec. (s)(3)(A)(iii). Pub. L. 108–173, § 736(e)(5), substituted ''preexisting'' for ''pre-existing''.

Subsec. (s)(3)(C)(ii). Pub. L. 108–173, § 104(a)(2)(A), designated existing provisions as subcl. (I), substituted ''Subject to subclause (II), only'' for ''Only'', and added subcl. (II).

Subsec. (s)(3)(C)(iii). Pub. L. 108–173, § 104(a)(2)(B), inserted ''and subject to subsection (v)(1)'' after ''subparagraph (B)(vi)''.

Subsec. (v). Pub. L. 108–173, § 104(a)(1), added subsec. (v).

Subsec. (w). Pub. L. 108–173, § 104(b)(1), added subsec. (w).

2000—Subsec. (s)(3)(A). Pub. L. 106–554, § 1(a)(6) [title VI, § 618(a)(1)], in concluding provisions, substituted ''seeks to enroll under the policy during the period specified in subparagraph (E)'' for '', subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph''.

Subsec. (s)(3)(E). Pub. L. 106–554, § 1(a)(6) [title VI, § 618(a)(2)], added subpar. (E) and struck out former subpar. (E) which read as follows:

''(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

''(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved.''

Subsec. (s)(3)(F). Pub. L. 106–554, § 1(a)(6) [title VI, § 618(b)], added subpar. (F).

1999—Subsec. (g)(1). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(13)], struck out ''or'' after ''; but does not include''.

Subsec. (q)(5)(C). Pub. L. 106–170, § 205(a)(1), inserted ''or paragraph (6)'' after ''this paragraph''.

Subsec. (q)(6). Pub. L. 106–170, § 205(a)(2), added par. (6).

Subsec. (s)(2)(D). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(14)], inserted ''section'' after ''(as defined in'' in introductory provisions.

Subsec. (s)(3)(A). Pub. L. 106–113, § 1000(a)(6) [title V, § 501(a)(2)(A)], inserted '', subject to subparagraph (E),'' after ''in the case of an individual described in subparagraph (B) who'' in concluding provisions.

Subsec. (s)(3)(B)(ii). Pub. L. 106–113, § 1000(a)(6) [title V, § 536(a)(1)], inserted before period at end ''or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan''.

Subsec. (s)(3)(B)(v)(II). Pub. L. 106–113, § 1000(a)(6) [title V, § 536(a)(2)], inserted ''any PACE provider under

section 1395eee of this title,'' after ''demonstration project authority,''.

Subsec. (s)(3)(B)(vi). Pub. L. 106–113, §1000(a)(6) [title V, §536(a)(3)], inserted ''or in a PACE program under section 1395eee of this title'' after ''part C'' and substituted ''such plan or such program'' for ''such plan''.

Subsec. (s)(3)(E). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(2)(B)], added subpar. (E).

1998—Subsec. (*l*)(6). Pub. L. 105–362 struck out par. (6) which read as follows: ''The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).''

1997—Subsec. (d)(3)(A)(i). Pub. L. 105–33, §4003(a)(1)(A), inserted ''(including an individual electing a Medicare+Choice plan under section 1395w–21 of this title)'' after ''part B of this subchapter'' in introductory provisions.

Subsec. (d)(3)(A)(i)(II). Pub. L. 105–33, §4003(a)(1)(B), inserted ''in the case of an individual not electing a Medicare+Choice plan'' after ''(II)'' and inserted ''or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy'' before comma at end.

Subsec. (d)(3)(A)(vi)(III). Pub. L. 105–33, §4031(c), inserted '', a policy described in clause (v),'' after ''Medicare supplemental policy''.

Subsec. (d)(3)(B)(i)(I). Pub. L. 105–33, §4003(a)(2), inserted ''(including any Medicare+Choice plan)'' after ''health insurance policies''.

Subsec. (g)(1). Pub. L. 105–33, §4003(a)(3), inserted ''or a Medicare+Choice plan or'' after ''does not include'' the first place appearing.

Pub. L. 105–33, §4002(j)(2), struck out '', during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995,'' after ''Omnibus Budget Reconciliation Act of 1986, or''.

Subsec. (p)(2)(C). Pub. L. 105–33, §4032(a)(1), inserted before period at end ''plus the 2 plans described in paragraph (11)(A)''.

Subsec. (p)(11). Pub. L. 105–33, §4032(a)(2), added par. (11).

Subsec. (s)(2)(B). Pub. L. 105–33, §4031(b)(1), substituted ''subparagraphs (C) and (D)'' for ''subparagraph (C)''.

Subsec. (s)(2)(D). Pub. L. 105–33, §4031(b)(2), added subpar. (D).

Subsec. (s)(3). Pub. L. 105–33, §4031(a)(3), added par. (3). Former par. (3) redesignated (4).

Pub. L. 105–33, §4031(a)(1), (2), substituted ''requirements of this subsection'' for ''requirements of paragraphs (1) and (2)'' and redesignated par. (3) as (4).

Subsec. (s)(4). Pub. L. 105–33, §4031(a)(2), redesignated par. (3) as (4).

Subsec. (u). Pub. L. 105–33, §4003(b), added subsec. (u).

1996—Subsec. (d)(3)(A)(iii). Pub. L. 104–191, §271(a)(1), substituted ''clause (i)(II)'' for ''clause (i)''.

Subsec. (d)(3)(A)(iv) to (viii). Pub. L. 104–191, §271(a)(2), added cls. (iv) to (viii).

Subsec. (d)(3)(C). Pub. L. 104–191, §271(b)(1), substituted ''with respect to'' for ''with respect to (i)'' and struck out before period at end '', (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under subchapter XIX of this chapter) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this subchapter, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual''.

Subsec. (d)(3)(D). Pub. L. 104–191, §271(b)(2), struck out subpar. (D) which provided for development of statements for various types of health insurance policies sold or issued to persons entitled to health benefits under this subchapter regarding extent to which benefits payable under those policies duplicate benefits under this subchapter.

1994—Subsec. (a)(2). Pub. L. 103–432, §171(c)(1)(B), in closing provisions substituted ''on and after the effective date specified in subsection (p)(1)(C)'' for ''after the effective date of the NAIC or Federal standards with respect to the policy''.

Subsec. (a)(2)(A). Pub. L. 103–432, §171(c)(1)(A), substituted ''1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC standards or the Federal standards''.

Subsec. (b)(1). Pub. L. 103–432, §171(e)(2), substituted ''subparagraph (F)'' for ''subsection (F)'' in last sentence.

Pub. L. 103–432, §171(c)(4), substituted ''the Secretary determines'' for ''the the Secretary determines'' in introductory provisions.

Pub. L. 103–432, §171(c)(2), in last sentence substituted ''Each report'' for ''The report'', ''fail to meet the standards and requirements'' for ''fail to meet the standards'', ''compliance, information regarding'' for ''compliance, and information regarding'', and ''Commissioners may specify'' for ''Commissioners, may specify''.

Subsecs. (b)(1)(B), (c)(5). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment notes below.

Subsec. (d)(3)(A). Pub. L. 103–432, §171(d)(1)(D), struck out at end ''This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section.''

Pub. L. 103–432, §171(d)(1)(C), designated third sentence as cl. (iii), substituted ''clause (i) with respect to the sale of a medicare supplemental policy'' for ''the previous sentence'', and struck out ''and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled'' after ''compliance with subparagraph (B)''.

Pub. L. 103–432, §171(d)(1)(B), designated second sentence as cl. (ii) and substituted ''Whoever violates clause (i)'' for ''Whoever violates the previous sentence''.

Pub. L. 103–432, §171(d)(1)(A), designated first sentence as cl. (i) and amended it generally. Prior to amendment, first sentence read as follows: ''It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this subchapter or subchapter XIX of this chapter).''

Subsec. (d)(3)(B)(ii)(II). Pub. L. 103–432, §171(d)(2)(A), struck out ''65 years of age or older'' before ''may be eligible''.

Subsec. (d)(3)(B)(iii)(I). Pub. L. 103–432, §171(d)(2)(B), (C), substituted ''has a medicare supplemental policy'' for ''has another medicare supplemental policy'' and ''sale of a medicare supplemental policy'' for ''sale of such a policy''.

Subsec. (d)(3)(B)(iii)(II). Pub. L. 103–432, §171(d)(2)(D), substituted ''has a medicare supplemental policy'' for ''has another policy''.

Subsec. (d)(3)(B)(iii)(III). Pub. L. 103–432, §171(d)(2)(E), amended subcl. (III) generally. Prior to amendment,

subcl. (III) read as follows: ''Subclause (I) also shall not apply if a State medicaid plan under subchapter XIX of this chapter pays the premiums for the policy, or pays less than an individual's (who is described in section 1396d(p)(1) of this title) full liability for medicare cost sharing as defined in section 1396d(p)(3)(A) of this title.''

Subsec. (d)(3)(C). Pub. L. 103–432, §171(d)(3)(A), substituted ''(i) the sale or issuance of a group policy'' for ''the selling of a group policy'' and added cls. (ii) and (iii).

Subsec. (d)(3)(D). Pub. L. 103–432, §171(d)(3)(B), added subpar. (D).

Subsec. (d)(4)(D). Pub. L. 103–432, §171(k)(1), struck out before period at end '', if such policy expires not more than 12 months after the date on which the duplicate copy is mailed''.

Subsec. (d)(4)(E). Pub. L. 103–432, §171(k)(2), added subpar. (E).

Subsec. (f)(3). Pub. L. 103–432, §171(j)(2), added par. (3).

Subsec. (g)(1). Pub. L. 103–432, §171(f)(1), substituted ''an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1395*l*(a)(1)(A) of this title'' for ''a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under section 1395mm of this title or an agreement under section 1395*l* of this title.''

Subsec. (g)(2)(B). Pub. L. 103–432, §171(c)(3), substituted ''Secretary'' for ''Panel''.

Subsec. (*o*). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment note below.

Subsec. (p). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment note below.

Subsec. (p)(1)(A). Pub. L. 103–432, §171(a)(2)(A), in introductory provisions, substituted ''changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate'' for ''promulgates'', and in closing provisions, struck out ''(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards'),'' before ''subsection (g)(2)(A)'' and substituted ''were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')'' for ''included a reference to the NAIC standards''.

Subsec. (p)(1)(B). Pub. L. 103–432, §171(a)(2)(B), substituted ''make the changes in the revised NAIC Model Regulation'' for ''promulgate NAIC standards'', ''a regulation'' for ''limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')'', and ''were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')'' for ''included a reference to the Federal standards''.

Subsec. (p)(1)(C)(i). Pub. L. 103–432, §171(a)(2)(C), substituted ''1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC standards or the Federal standards''.

Subsec. (p)(1)(C)(ii)(I), (E). Pub. L. 103–432, §171(a)(2)(D), substituted ''1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC or Federal standards''.

Subsec. (p)(2). Pub. L. 103–432, §171(a)(2)(D), substituted ''1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC or Federal standards'' in introductory provisions.

Subsec. (p)(2)(C). Pub. L. 103–432, §171(a)(2)(E), substituted ''paragraph (4)(B)'' for ''paragraph (5)(B)''.

Subsec. (p)(4). Pub. L. 103–432, §171(a)(2)(G), substituted ''applicable 1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''applicable standards'' wherever appearing.

Subsec. (p)(4)(A)(i). Pub. L. 103–432, §171(a)(2)(F), inserted ''or paragraph (6)'' after ''subparagraph (B)''.

Subsec. (p)(6). Pub. L. 103–432, §171(a)(2)(H), substituted ''described in clauses (i) through (iii) of paragraph (1)(A)'' for ''in regard to the limitation of benefits described in paragraph (4)''.

Subsec. (p)(7). Pub. L. 103–432, §171(a)(2)(I), substituted ''policyholders'' for ''policyholder''.

Subsec. (p)(8). Pub. L. 103–432, §171(a)(2)(J), substituted ''on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (*o*) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)'' for ''after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection''.

Subsec. (p)(9)(B). Pub. L. 103–432, §171(a)(2)(D), substituted ''1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC or Federal standards''.

Subsec. (p)(9)(D). Pub. L. 103–432, §171(a)(2)(K), added subpar. (D).

Subsec. (p)(10). Pub. L. 103–432, §171(a)(2)(L), substituted ''consistent with paragraph (1)(A)(i)'' for ''consistent with this subsection''.

Subsec. (q)(2). Pub. L. 103–432, §171(b)(1), substituted ''paragraph (4)'' for ''paragraph (2)''.

Subsec. (q)(4). Pub. L. 103–432, §171(b)(2), substituted ''issuer of the replacement policy'' for ''the succeeding issuer''.

Subsec. (q)(5)(A), (B). Pub. L. 103–432, §171(d)(4), made technical amendment to the reference to subchapter XIX of this chapter to correct reference to corresponding provision of original act.

Subsec. (r)(1). Pub. L. 103–432, §171(e)(1)(A), (E), in introductory provisions substituted ''or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))'' for ''or sold'' and inserted at end of closing provisions ''For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.''

Subsec. (r)(1)(A). Pub. L. 103–432, §171(e)(1)(C), substituted ''Commissioners)'' for ''Commissioners,''.

Pub. L. 103–432, §171(e)(1)(B), inserted ''for periods after the effective date of these provisions'' after ''the policy can be expected''.

Subsec. (r)(1)(B). Pub. L. 103–432, §171(e)(1)(D), inserted before period at end '', treating policies of the same type as a single policy for each standard package''.

Subsec. (r)(2)(A). Pub. L. 103–432, §171(e)(1)(F)–(I), substituted ''by standard package'' for ''by policy number'' in first sentence and ''until 12 months following issue'' for ''with respect to the first 2 years in which it is in effect'' in second sentence, struck out ''in order to apply paragraph (1)(B) to the first 2 years in which policies are effective'' after ''may be appropriate'' in third sentence, and inserted at end ''In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.''

Subsec. (r)(2)(C), (D). Pub. L. 103–432, §171(e)(1)(J), substituted ''calendar year'' for ''policy year'' wherever appearing.

Subsec. (r)(4). Pub. L. 103–432, §171(e)(1)(K), substituted ''October'' for ''February'', ''disallowance'' for ''disllowance'', ''loss ratios'' for ''loss-ratios'' in two places, and ''loss ratio'' for ''loss-ratio''.

Subsec. (r)(6)(A). Pub. L. 103–432, §171(e)(1)(L), substituted ''fails to provide refunds or credits as required in paragraph (1)(B)'' for ''issues a policy in violation of the loss ratio requirements of this subsection'' and ''policy issued for which such failure occurred'' for ''such violation''.

Subsec. (r)(6)(B). Pub. L. 103–432, §171(e)(1)(M), substituted ''to the policyholder or, in the case of a group policy, to the certificate holder'' for ''to policyholders''.

Subsec. (s)(2)(A). Pub. L. 103–432, §171(g)(1), (2), substituted ''in the case of an individual for whom an application is submitted prior to or'' for ''for which an application is submitted'' and ''as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B'' for ''in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B''.

Subsec. (s)(2)(B). Pub. L. 103–432, §171(g)(3), substituted ''before the policy became effective'' for ''before it became effective''.

Subsec. (t)(1). Pub. L. 103–432, §171(h)(1)(A), (B), substituted ''If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''If a policy meets the NAIC Model Standards''.

Subsec. (t)(1)(A). Pub. L. 103–432, §171(h)(1)(C), inserted ''or agreements'' after ''contracts''.

Subsec. (t)(1)(E)(i), (F). Pub. L. 103–432, §171(h)(1)(D), substituted ''standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation'' for ''NAIC standards''.

Subsec. (t)(2). Pub. L. 103–432, §171(h)(1)(E), inserted ''the issuer'' before ''is subject to a civil money penalty'' in concluding provisions.

1990—Pub. L. 101–508, §4353(a)(1), struck out ''Voluntary'' at beginning of section catchline.

Subsec. (a). Pub. L. 101–508, §4353(a)(2), designated existing provisions as par. (1) and added par. (2).

Pub. L. 101–508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103–432, §160(d)(4), struck out ''(k)(4),'' after ''subsections (k)(3),'' in third sentence.

Subsec. (b)(1). Pub. L. 101–508, §4353(c)(5), inserted at end ''The report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.''

Pub. L. 101–508, §4353(b)(1), (2), substituted ''the Secretary'' for ''Supplemental Health Insurance Panel (established under paragraph (2))'' in introductory provisions and for ''the Panel'' in concluding provisions.

Pub. L. 101–508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103–432, §160(d)(4), which directed the amendment of third sentence of par. (1) by striking out ''(k)(4),'' was executed by making the deletion after ''subsections (k)(3),'' in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(1)(A). Pub. L. 101–508, §4358(b)(2)(A), inserted before semicolon at end '', except as otherwise provided by subparagraph (H)''.

Pub. L. 101–508, §4353(b)(3), inserted ''and enforcement'' after ''application''.

Subsec. (b)(1)(B). Pub. L. 101–508, §4351(1), formerly §4351(a)(1), as renumbered and amended by Pub. L. 103–432, §171(a)(1), substituted ''through (5)'' for ''through (4)''.

Subsec. (b)(1)(C). Pub. L. 101–508, §4355(b), substituted for semicolon at end '', and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;''.

Subsec. (b)(1)(D). Pub. L. 101–508, §4353(b)(3), inserted ''and enforcement'' after ''application''.

Subsec. (b)(1)(F). Pub. L. 101–508, §4353(c)(1)–(3), added subpar. (F).

Subsec. (b)(1)(G). Pub. L. 101–508, §4355(c), which directed amendment of par. (1) by adding at the end thereof a new subpar. (G), was executed by adding the new subpar. (G) immediately after subpar. (F) to reflect the probable intent of Congress.

Subsec. (b)(1)(H). Pub. L. 101–508, §4358(b)(2)(B)–(D), added subpar. (H).

Subsec. (b)(2). Pub. L. 101–508, §4353(b)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

''(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the Secretary and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

''(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

''(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

''(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph.

''(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5.''

Subsec. (c). Pub. L. 101–508, §4357(a)(1), inserted ''or the requirement described in subsection (s)'' after ''paragraph (3)'' in introductory provisions.

Pub. L. 101–508, §4355(a)(2), struck out at end ''For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.''

Subsec. (c)(1). Pub. L. 101–508, §4358(b)(1), inserted before semicolon at end ''(except as otherwise provided by subsection (t))''.

Subsec. (c)(2). Pub. L. 101–508, §4355(a)(1), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies;''.

Subsec. (c)(5). Pub. L. 101–508, §4351(2), formerly §4351(a)(2), as renumbered and amended by Pub. L. 103–432, §171(a)(1), added par. (5).

Subsec. (d)(3)(A). Pub. L. 101–508, §4354(a)(1), substituted ''It is unlawful for a person to sell or issue'' for ''Whoever knowingly sells'', ''duplicates health benefits'' for ''substantially duplicates health benefits'', ''. Whoever violates the previous sentence shall be fined'' for '', shall be fined'', ''(other than this subchapter or subchapter XIX of this chapter)'' for ''(other than this subchapter)'', and ''$25,000 (or $15,000 in the case of a person other than the issuer of the policy)'' for ''$5,000'' and inserted at end ''A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the pol-

icy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section.''

Subsec. (d)(3)(B). Pub. L. 101–508, §4354(a)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.''

Subsec. (d)(4)(B). Pub. L. 101–508, §4353(d)(1), struck out at end ''For purposes of this paragraph, a medicare supplemental policy shall be deemed to be approved by the commissioner or superintendent of insurance of a State if—

''(i) the policy has been certified by the Secretary pursuant to subsection (c) of this section or was issued in a State with an approved regulatory program (as defined in subsection (g)(2)(B) of this section);

''(ii) the policy has been approved by the commissioners or superintendents of insurance in States in which more than 30 percent of such policies are sold; or

''(iii) the State has in effect a law which the commissioner or superintendent of insurance of the State has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy;

except that such a policy shall not be deemed to be approved by a State commissioner or superintendent of insurance if the State notifies the Secretary that such policy has been submitted for approval to the State and has been specifically disapproved by such State after providing appropriate notice and opportunity for hearing pursuant to the procedures (if any) of the State.''

Subsec. (g)(1). Pub. L. 101–508, §4356(a), inserted before period at end of first sentence ''and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under section 1395mm of this title or an agreement under section 1395*l* of this title''.

Subsecs. (*o*), (p). Pub. L. 101–508, §4351(3), formerly §4351(a)(3), as renumbered and amended by Pub. L. 103–432, §171(a)(1), added subsecs. (*o*) and (p).

Subsec. (q). Pub. L. 101–508, §4352, added subsec. (q).

Subsec. (q)(5). Pub. L. 101–508, §4354(b), added par. (5).

Subsec. (r). Pub. L. 101–508, §4355(a)(3), added subsec. (r).

Subsec. (s). Pub. L. 101–508, §4357(a)(2), added subsec. (s).

Subsec. (t). Pub. L. 101–508, §4358(a), added subsec. (t).

1989—Subsecs. (a), (b)(1). Pub. L. 101–234, §203(a)(1)(A), substituted ''subsections (k)(3), (k)(4), (m), and (n)'' for ''subsection (k)(3)''.

Subsec. (k)(1)(A). Pub. L. 101–234, §203(a)(1)(B)(i), inserted ''except as provided in subsection (m),'' before ''subsection (g)(2)(A)''.

Subsec. (k)(3). Pub. L. 101–234, §203(a)(1)(B)(ii), substituted ''subsections (*l*), (m), and (n)'' for ''subsection (*l*)''.

Subsecs. (m), (n). Pub. L. 101–234, §203(a)(1)(C), added subsecs. (m) and (n).

1988—Subsec. (a). Pub. L. 100–360, §221(d)(1), substituted ''Subject to subsection (k)(3), such'' for ''Such''.

Subsec. (b)(1). Pub. L. 100–360, §221(d)(2), substituted ''(subject to subsection (k)(3), for so long as'' for ''(for so long as'' in concluding provisions.

Subsec. (b)(1)(B). Pub. L. 100–360, §221(a)(1), substituted ''through (4)'' for ''and (3)''.

Subsec. (b)(1)(C). Pub. L. 100–360, §221(b)(2), (3), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100–360, §221(b)(1), substituted ''(A), (B), and (C)'' for ''(A) and (B)''.

Subsec. (b)(1)(D), (E). Pub. L. 100–360, §221(b)(2), redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsec. (b)(2)(A). Pub. L. 100–360, §221(f), substituted ''appointed by the Secretary'' for ''appointed by the President''.

Subsec. (b)(3). Pub. L. 100–360, §221(e), added par. (3).

Subsec. (c). Pub. L. 100–360, §411(i)(1)(B), added Pub. L. 100–203, §4081(b)(2)(A), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100–360, §411(i)(1)(B), redesignated Pub. L. 100–203, §4081(b)(2)(B)–(D), see 1987 Amendment note below.

Subsec. (c)(3)(A). Pub. L. 100–360, §411(i)(1)(C)(i), substituted ''claim form'' for ''claims form'' in two places and ''such notice'' for ''such claims form''.

Subsec. (c)(3)(B)(i). Pub. L. 100–360, §411(i)(1)(C)(ii), inserted ''under the policy'' after ''payment determination''.

Subsec. (c)(3)(B)(ii). Pub. L. 100–360, §411(i)(1)(C)(iii), substituted ''payment covered by such policy'' for ''appropriate payment''.

Subsec. (c)(4). Pub. L. 100–360, §221(a)(2), added par. (4).

Subsec. (d). Pub. L. 100–360, §428(b)(1), substituted ''shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act'' for ''shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both'' in pars. (1), (2), (3)(A), and (4)(A).

Subsec. (d)(5). Pub. L. 100–360, §428(b)(2), added par. (5).

Subsec. (e). Pub. L. 100–360, §221(c), designated existing provision as par. (1) and added pars. (2) and (3).

Subsecs. (k), (*l*). Pub. L. 100–360, §221(d)(3), added subsecs. (k) and (*l*).

1987—Subsec. (b)(1)(B). Pub. L. 100–203, §4081(b)(1)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''includes a requirement equal to or more stringent than the requirement described in subsection (c)(2) of this section; and''.

Subsec. (b)(1)(D). Pub. L. 100–203, §4081(b)(1)(B), (C), added subpar. (D).

Subsec. (c). Pub. L. 100–203, §4081(b)(2)(A), as added by Pub. L. 100–360, §411(i)(1)(B), inserted ''(or, with respect to paragraph (3), the issuer of the policy)'' in introductory provisions.

Subsec. (c)(3). Pub. L. 100–203, §4081(b)(2)(B)–(D), formerly §4081(b)(2), as redesignated by Pub. L. 100–360, §411(i)(1)(B), added par. (3).

Subsec. (d)(1). Pub. L. 100–93 substituted ''knowingly and willfully'' for ''knowingly or willfully''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Committee on Interstate and Foreign Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives immediately prior to noon on Jan. 3, 1981, by House Resolution No. 549, Ninety-sixth Congress, Mar. 25, 1980. Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104–14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on

Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–233, title I, §104(c), May 21, 2008, 122 Stat. 903, provided that: ''The amendments made by this section [amending this section] shall apply with respect to an issuer of a medicare supplemental policy for policy years beginning on or after the date that is 1 year after the date of enactment of this Act [May 21, 2008].''

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106–170, title II, §205(b), Dec. 17, 1999, 113 Stat. 1900, provided that: ''The amendments made by subsection (a) [amending this section] apply with respect to requests made after the date of the enactment of this Act [Dec. 17, 1999].''

Amendment by section 1000(a)(6) [title III, §321(k)(13), (14)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title V, §501(a)(2)] of Pub. L. 106–113 applicable to notices of impending terminations or discontinuances made on or after Nov. 29, 1999, see section 1000(a)(6) [title V, §501(d)(1)] of Pub. L. 106–113, set out as a note under section 1395w–21 of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §536(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–391, provided that: ''The amendments made by this section [amending this section] shall apply to terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4002(j)(2), Aug. 5, 1997, 111 Stat. 330, provided that the amendment made by that section is effective Jan. 1, 1999.

Pub. L. 105–33, title IV, §4031(d), Aug. 5, 1997, 111 Stat. 357, provided that:

''(1) GUARANTEED ISSUE.—The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1998.

''(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) [amending this section] shall apply to policies issued on or after July 1, 1998.

''(3) CONFORMING AMENDMENT.—The amendment made by subsection (c) [amending this section] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191].''

Pub. L. 105–33, title IV, §4032(b), Aug. 5, 1997, 111 Stat. 359, provided that:

''(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall take effect the date of the enactment of this Act [Aug. 5, 1997].

''(2) TRANSITION.—The provisions of section 4031(e) [set out as a note below] shall apply with respect to this section in the same manner as they apply to section 4031 [amending this section and enacting provisions set out as notes below].''

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §271(d), Aug. 21, 1996, 110 Stat. 2036, provided that:

''(1) Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508].

''(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(vi)], as added by subsection (a), shall only apply to individuals applying for—

''(i) a health insurance policy described in section 1882(d)(3)(A)(iv) of such Act (as added by subsection (a)), after the date of the enactment of this Act [Aug. 21, 1996], or

''(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

''(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act (as in effect before the date of the enactment of this Act), without the revision specified in such clause.''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §171(*l*), Oct. 31, 1994, 108 Stat. 4451, provided that: ''The amendments made by this section [amending this section and sections 1320c–3, 1395b–2, and 1395b–4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes below] shall be effective as if included in the enactment of OBRA–1990 [Pub. L. 101–508]; except that—

''(1) the amendments made by subsection (d)(1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994], but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] (for an action occurring after the effective date of the amendments made by section 4354 of OBRA–1990 [see section 4354(c) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note below] and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(i)(II)] (as amended by this section);

''(2) the amendments made by subsection (d)(2)(A) [amending this section] and by subparagraphs (A), (B), and (E) of subsection (e)(1) [amending this section] shall be effective on the date specified in subsection (m)(4) [set out as a note below]; and

''(3) the amendment made by subsection (g)(2) [amending this section] shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act [42 U.S.C. 1395ss(s)(2), for effective date see section 4357(b) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note below] (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995).''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4353(d)(2), Nov. 5, 1990, 104 Stat. 1388–130, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991.''

Pub. L. 101–508, title IV, §4354(c), Nov. 5, 1990, 104 Stat. 1388–132, provided that: ''The amendments made by this section [amending this section] shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4355(d), Nov. 5, 1990, 104 Stat. 1388–134, as amended by Pub. L. 103–432, title I, §171(e)(3), Oct. 31, 1994, 108 Stat. 4449, provided that: ''The amendments made by this section [amending this section] shall apply to policies issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act [42 U.S.C. 1395ss(p)(1)(C)]) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act.''

Pub. L. 101–508, title IV, §4356(b), Nov. 5, 1990, 104 Stat. 1388–134, as amended by Pub. L. 103–432, title I, §171(f)(2), Oct. 31, 1994, 108 Stat. 4449, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date specified in

section 1882(p)(1)(C) of the Social Security Act [42 U.S.C. 1395ss(p)(1)(C)].''

Pub. L. 101–508, title IV, § 4357(b), Nov. 5, 1990, 104 Stat. 1388–135, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Nov. 5, 1990].''

Amendment by section 4358(a), (b)(1), (2) of Pub. L. 101–508 only applicable in 15 States (as determined by Secretary of Health and Human Services) and such other States as elect such amendment to apply to them, and during the 6½-year period beginning with 1992, with such amendment to remain in effect beyond the 6½-year period unless the Secretary makes certain determinations, see section 4358(c) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title II, § 203(e), Dec. 13, 1989, 103 Stat. 1985, provided that: ''The provisions of this section [amending this section, enacting provisions set out as notes under sections 1395b–2 and 1395mm of this title, and amending provisions set out as a note under this section] shall take effect January 1, 1990, except that the amendment made by subsection (d) [amending provisions set out as an Effective Date of 1988 Amendment note under this section] shall be effective as if included in the enactment of MCCA [Pub. L. 100–360].''

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–360, title II, § 221(g), July 1, 1988, 102 Stat. 746, as amended by Pub. L. 100–485, title VI, § 608(d)(12), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, § 203(d), Dec. 13, 1989, 103 Stat. 1985, provided that:

''(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988].

''(2) The amendments made by subsections (a) and (b) [amending this section] shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act [42 U.S.C. 1395ss(k)(1)(B), (2)(B)] (as added by subsection (d) of this section).

''(3) The amendment made by subsection (e) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

''(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act [42 U.S.C. 1395ss(b)(2)]) by not later than 90 days after the date of the enactment of this Act [July 1, 1988].''

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(i)(1)(B), (C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Amendment by section 428(b) of Pub. L. 100–360 effective July 1, 1988, and applicable only with respect to violations occurring on or after such date, see section 428(c) of Pub. L. 100–360, set out as an Effective Date note under section 1320b–10 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4081(c)(2), Dec. 22, 1987, 101 Stat. 1330–128, as amended by Pub. L. 100–360, title IV, § 411(i)(1)(D), (E), July 1, 1988, 102 Stat. 788; Pub. L. 100–485, title VI, § 608(d)(24)(A), Oct. 13, 1988, 102 Stat. 2421, provided that:

''(A) The amendments made by subsection (b) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989 (or, if applicable, the date established under subparagraph (B)).

''(B) In the case of a State which the Secretary of Health and Human Services identifies as—

''(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to be changed to meet the requirements of section 1882(c)(3) of the Social Security Act [42 U.S.C. 1395ss(c)(3)], and

''(ii) having a legislature which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered or which has not enacted such legislation before July 1, 1988,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered.''

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE

Pub. L. 96–265, title V, § 507(b), June 9, 1980, 94 Stat. 481, provided that: ''The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [June 9, 1980], except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act [42 U.S.C. 1395ss(d)(4)] (as added by this section) shall become effective on July 1, 1982.''

RULE OF CONSTRUCTION

Pub. L. 108–173, title I, § 104(c), Dec. 8, 2003, 117 Stat. 2165, provided that:

''(1) IN GENERAL.—Nothing in this Act [see Tables for classification] shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.], as added by section 101, as a condition for issuing such policy.

''(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under such part D as a condition for issuing such policy.''

IMPLEMENTATION OF NAIC RECOMMENDATIONS

Pub. L. 110–275, title I, § 104(a), July 15, 2008, 122 Stat. 2501, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section [enacting section 1395ss–1 of this title and amending this section] referred to as the 'Secretary') shall provide for implementation of the changes in the NAIC model law and regulations approved by the National Association of Insurance Commissioners in its Model #651 ('Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act') on March 11, 2007, as modified to reflect the changes made under this Act [see Short Title of 2008 Amendment note set out under section 1305 of this title] and the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) [see Short Title note set out under section 2000ff of this title].

''(2) IMPLEMENTATION DATES.—

''(A) IN GENERAL.—The modifications to Model #651 required under paragraph (1) shall be completed by the National Association of Insurance Commissioners not later than October 31, 2008. Except as provided in subparagraph (B), each State shall have 1 year from the date the National Association of Insurance Commissioners adopts the revised NAIC model law and regulations (as changed by Model #651, as so modified) to conform the regulatory program established by the State to such revised NAIC model law and regulations.

''(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State which the Secretary determines requires State legislation in order to conform the regulatory program established by the State to such revised NAIC model law and regulations, the State shall not be regarded as failing to comply with the requirements of this section solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 15, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

''(C) TRANSITION DATES.—No carrier may issue a new or revised medicare supplemental policy or certificate under section 1882 of the Social Security Act (42 U.S.C. 1395ss) that meets the requirements of such revised NAIC model law and regulations for coverage effective prior to June 1, 2010. A carrier may continue to offer or issue a medicare supplemental policy under such section that meets the requirements of the NAIC model law and regulations and State law (as in effect prior to the adoption of such revised NAIC model law and regulations) prior to June 1, 2010. Nothing shall preclude carriers from marketing new or revised medicare supplemental policies or certificates that meet the requirements of such revised NAIC model law and regulations on or after the date on which the State conforms the regulatory program established by the State to such revised NAIC model law and regulations.''

STUDY OF MEDIGAP POLICIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §553(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

''(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the 'Comptroller General') shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

''(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

''(A) The level of coverage provided by each type of medicare supplemental policy.

''(B) The current enrollment levels in each type of medicare supplemental policy.

''(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65½.

''(D) The number and type of medicare supplemental policies offered in each State.

''(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

''(2)[(3)] REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.''

CONFORMING BENEFITS TO CHANGES IN TERMINOLOGY FOR HOSPITAL OUTPATIENT DEPARTMENT COST SHARING

Pub. L. 105–33, title IV, §4031(f), Aug. 5, 1997, 111 Stat. 359, provided that: ''For purposes of apply [sic] section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e) [set out as a note above], copayment amounts provided under section 1833(t)(5) of such Act [42 U.S.C. 1395*l*(t)(5)] with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services.''

TRANSITION PROVISIONS

Pub. L. 110–233, title I, §104(d), May 21, 2008, 122 Stat. 903, provided that:

''(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

''(2) NAIC STANDARDS.—If, not later than October 31, 2008, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act [42 U.S.C. 1395ss] (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section [amending this section], such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

''(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall, not later than July 1, 2009, make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

''(4) DATE SPECIFIED.—

''(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

''(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

''(ii) July 1, 2009.

''(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

''(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

''(ii) having a legislature which is not scheduled to meet in 2009 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2009. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 105–33, title IV, §4031(e), Aug. 5, 1997, 111 Stat. 358, provided that:

''(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

''(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act [Aug. 5, 1997], the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act [42 U.S.C. 1395ss] (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) [set out as a note below] and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act [42

U.S.C. 1395ss(d)(3)(A)(vi)(IV)], as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section [amending this section], such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

''(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

''(4) DATE SPECIFIED.—

''(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

''(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

''(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

''(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

''(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

''(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

Pub. L. 104–191, title II, § 271(c), Aug. 21, 1996, 110 Stat. 2036, provided that:

''(1) NO PENALTIES.—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

''(2) LIMITATION ON LEGAL ACTION.—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

''(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

''(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

''(3) DISCLOSURE CONDITION.—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 [Pub. L. 103–432, set out below] and before the end of the 30-day period beginning on the date of the enactment of this Act [Aug. 21, 1996], paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act (as in effect before the date of the enactment of this Act).

''(4) TRANSITION PERIOD.—In this subsection, the term 'transition period' means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act.''

APPLICABILITY OF DISCLOSURE REQUIREMENT

Pub. L. 103–432, title I, § 171(d)(3)(C), Oct. 31, 1994, 108 Stat. 4448, provided that: ''The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(C)(ii)] shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act.''

STATE REGULATORY PROGRAMS

Pub. L. 103–432, title I, § 171(m), Oct. 31, 1994, 108 Stat. 4451, provided that:

''(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section and sections 1320c–3, 1395b–2, and 1395b–4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes under this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

''(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act [Oct. 31, 1994], the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with 'unless', such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

''(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

''(4) DATE SPECIFIED.—

''(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

''(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

''(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

''(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

''(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

''(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''

EVALUATION OF 1990 AMENDMENTS

Pub. L. 101–508, title IV, § 4358(d), Nov. 5, 1990, 104 Stat. 1388–137, provided that: ''The Secretary of Health

and Human Services shall conduct an evaluation of the amendments made by this section [amending this section and section 1320c–3 of this title] and shall report to Congress on such evaluation by not later than January 1, 1995.''

§ 1395ss–1. Clarification

Any health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] but which are not reimbursable by reason of the applicability of deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under part C of such title [42 U.S.C. 1395w–21 et seq.] shall comply with the requirements of section 1882(*o*) of the such[1] Act (42 U.S.C. 1395ss(*o*)).

(Pub. L. 110–275, title I, § 104(c), July 15, 2008, 122 Stat. 2502.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part C of title XVIII of the Act is classified to section 1395w–21 et seq. of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Improvements for Patients and Providers Act of 2008, and not as part of the Social Security Act which comprises this chapter.

§ 1395tt. Hospital providers of extended care services

(a) Hospital facility agreements; reasonable costs of services

(1) Any hospital which has an agreement under section 1395cc of this title may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this subchapter, payment to any hospital (other than a critical access hospital) for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under subsections (a) through (d) of section 1395yy of this title for subsequent cost reporting periods and up to and including such calendar year) under this subchapter to freestanding skilled nursing facilities in the region (as defined in section 1395ww(d)(2)(D) of this title) in which the facility is located.

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(3) Notwithstanding any other provision of this subchapter, a critical access hospital shall be paid for covered skilled nursing facility services furnished under an agreement entered into under this section on the basis of equal to 101 percent of the reasonable costs of such services (as determined under section 1395x(v) of this title).

(b) Eligible facilities

The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.

(c) Terms and conditions of facility agreements

An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1395cc of this title and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1395cc of this title; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1395cc of this title. A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Post-hospital extended care services

Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1395cc of this title; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this subchapter (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been

[1] So in original.

post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1395cc of this title.

(e) Reimbursement for routine hospital services

During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including this subchapter, subchapter XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine this subchapter reimbursement for routine hospital services.

(f) Conditions applicable to skilled nursing facilities

A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1395i–3 of this title. Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) Agreements on demonstration basis

The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1883, as added Pub. L. 96–499, title IX, § 904(a)(1), Dec. 5, 1980, 94 Stat. 2615; amended Pub. L. 100–203, title IV, §§ 4005(b)(1), (2), 4201(d)(3), Dec. 22, 1987, 101 Stat. 1330–48, as amended Pub. L. 100–360, title IV, § 411(*l*)(1)(C), July 1, 1988, as added Pub. L. 100–485, title VI, § 608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title I, § 104(d)(6), title IV, § 411(b)(4)(D), July 1, 1988, 102 Stat. 689, 770; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–508, title IV, § 4008(j)(1), Nov. 5, 1990, 104 Stat. 1388–51; Pub. L. 105–33, title IV, § 4432(b)(5)(G), Aug. 5, 1997, 111 Stat. 422; Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, §§ 403(f), 408(a), (b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, 1501A–375; Pub. L. 106–554, § 1(a)(6) [title II, § 203(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482; Pub. L. 108–173, title IV, § 405(a)(1), Dec. 8, 2003, 117 Stat. 2266.)

Editorial Notes

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108–173 inserted ''equal to 101 percent of'' before ''the reasonable costs''.

2000—Subsec. (a)(2)(A). Pub. L. 106–554, § 1(a)(6) [title II, § 203(b)(1)], inserted ''(other than a critical access hospital)'' after ''any hospital''.

Subsec. (a)(3). Pub. L. 106–554, § 1(a)(6) [title II, § 203(b)(2)], added par. (3).

1999—Subsec. (a)(1). Pub. L. 106–113, § 1000(a)(6) [title IV, § 403(f)(1)], struck out ''(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title)'' after ''Any hospital''.

Subsec. (b). Pub. L. 106–113, § 1000(a)(6) [title IV, § 408(a)], amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: ''The Secretary may not enter into an agreement under this section with any hospital unless—

''(1) except as provided under subsection (g) of this section, the hospital is located in a rural area and has less than 100 beds, and

''(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.''

Subsec. (c). Pub. L. 106–113, § 1000(a)(6) [title IV, § 403(f)(2)], struck out '', or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title'' before the period at end of first sentence.

Subsec. (d). Pub. L. 106–113, § 1000(a)(6) [title IV, § 408(b)], struck out ''(1)'' before ''Any agreement with a hospital'' and struck out pars. (2) and (3), which related to limiting payments under extended care service agreements pursuant to this section to hospitals with more than 49 beds where skilled nursing facilities were available or where such payments exceeded a designated maximum.

1997—Subsec. (a)(2)(B)(ii)(II). Pub. L. 105–33 inserted ''subsections (a) through (d) of'' before ''section 1395yy''.

1990—Subsec. (a)(2)(B)(ii)(II). Pub. L. 101–508 substituted ''the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1395yy of this title for subsequent cost reporting periods and up to and including such calendar year) under this subchapter to free-standing skilled nursing facilities in the region (as defined in section 1395ww(d)(2)(D) of this title) in which the facility is located.'' for ''the previous calendar year'' and all that follows through the period, which was executed by making the substitution for ''the previous calendar year under the State plan (of the State in which the hospital is located) under subchapter XIX of this chapter to skilled nursing facilities located in the State and which meet the requirements specified in section 1396a(a)(28) of this title, or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this subchapter to skilled nursing facilities in such State.''

1989—Subsecs. (d)(1), (f). Pub. L. 101–234 repealed Pub. L. 100–360, § 104(d)(6), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (d)(1). Pub. L. 100–360, § 104(d)(6), struck out ''post-hospital'' before ''extended care services'' wherever appearing.

Subsec. (d)(3). Pub. L. 100–360, § 411(b)(4)(D), inserted before period at end '', except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph''.

Subsec. (f). Pub. L. 100–360, § 411(*l*)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), added Pub. L. 100–203, § 4201(d)(3), see 1987 Amendment note below.

Pub. L. 100–360, § 104(d)(6), struck out ''post-hospital'' before ''extended care services''.

1987—Subsec. (b)(1). Pub. L. 100–203, § 4005(b)(1), substituted ''100'' for ''50''.

Subsec. (d). Pub. L. 100–203, § 4005(b)(2), designated existing provisions as par. (1) and added pars. (2) and (3).

Subsec. (f). Pub. L. 100–203, § 4201(d)(3), as added by Pub. L. 100–360, § 411(*l*)(1)(C), and Pub. L. 100–485, § 608(d)(27)(B), substituted ''section 1395i–3'' for ''section 1395x(j)(15)''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to payments for services furnished during cost reporting periods beginning on or after Jan. 1, 2004, see section 405(a)(2) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title II, § 203(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482, provided that: ''The amendments made by this section [amending this section and section 1395yy of this title] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 408(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–375, provided that: ''The amendments made by this section [amending this section] take effect on the date that is the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(E)) for payments for covered skilled nursing facility services under the medicare program.''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4008(j)(4), Nov. 5, 1990, 104 Stat. 1388–52, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after October 1, 1990.''

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(6) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(4)(D), (*l*)(1)(C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4005(b)(4), Dec. 22, 1987, 101 Stat. 1330–49, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section] shall apply to agreements under section 1883 of the Social Security Act [42 U.S.C. 1395tt] entered into after March 31, 1988.''

Amendment by section 4201(d)(3) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendment are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE

Pub. L. 96–499, title IX, § 904(d), Dec. 5, 1980, 94 Stat. 2617, provided that: ''The amendments made by this section [enacting this section and section 1396*l* of this title] shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980].''

HOLD HARMLESS FOR AMENDMENT BY PUB. L. 101–508

Pub. L. 101–508, title IV, § 4008(j)(2), Nov. 5, 1990, 104 Stat. 1388–51, provided that: ''If, as a result of the amendment made by paragraph (1) [amending this section], the reasonable cost of routine services furnished by a hospital during a calendar year (as determined under section 1883 of the Social Security Act [42 U.S.C. 1395tt]) is less than the reasonable cost of such services determined under such section for the previous calendar year, the reasonable cost of such services furnished by the hospital during the calendar year under such section shall be equal to the reasonable cost determined under such section for the previous calendar year.''

SWING BEDS CERTIFIED PRIOR TO MAY 1, 1987

Pub. L. 101–508, title IV, § 4008(j)(3), Nov. 5, 1990, 104 Stat. 1388–52, provided that: ''Notwithstanding the requirement of section 1883(b)(1) of the Social Security Act [42 U.S.C. 1395tt(b)(1)] that the Secretary may not enter into an agreement under such section with a hospital that is not located in a rural area, any agreement entered into under such section on or before May 1, 1987, between the Secretary of Health and Human Services and a hospital located in an urban area shall remain in effect.''

REPORT OF HOSPITAL ADMISSIONS FOR EXTENDED CARE SERVICES

Pub. L. 100–203, title IV, § 4005(b)(3), Dec. 22, 1987, 101 Stat. 1330–49, as amended by Pub. L. 100–360, title IV, § 411(b)(4)(E), as added by Pub. L. 100–485, title VI, § 608(d)(18)(C), Oct. 13, 1988, 102 Stat. 2419, directed Secretary of Health and Human Services to report to Congress, not later than Feb. 1, 1989, concerning the proportion of admissions to hospitals for extended care services under this section which are denied or approved by a peer review organization, and recommendations for methods of encouraging hospitals that have a low occupancy rate, are eligible to enter (but have not entered) into an agreement under this section, and are located in areas with a need for additional providers of extended care services, to enter into such agreements.

REPORT ON HOSPITAL PROVIDERS OF EXTENDED CARE, SKILLED NURSING, AND INTERMEDIATE CARE SERVICES

Pub. L. 96–499, title IX, § 904(c), Dec. 5, 1980, 94 Stat. 2617, directed Secretary of Health and Human Services, within three years after Dec. 5, 1980, to submit to Congress a report evaluating programs established by the amendments made by this section (enacting this section and section 1396*l* of this title), including in such report an analysis of the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care serv-

ices, whether such programs should be continued, the results of any demonstration projects conducted under such programs, and whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

§ 1395uu. Payments to promote closing or conversion of underutilized hospital facilities

(a) Transitional allowances; procedures applicable

Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this subchapter with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

(b) Allowable costs as transitional allowances; findings and determinations

If the Secretary finds, after consideration of an application under subsection (a), that—

(1) the hospital's closure or conversion—

(A) is formally initiated after September 30, 1981,

(B) is expected to benefit the program under this subchapter by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

(2) in the case of a complete closure of a hospital—

(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

(B) the closure is not for replacement of the hospital,

the Secretary may include as an allowable cost in the hospital's reasonable cost (for the purpose of making payments to the hospital under this subchapter) an amount (in this section referred to as a ''transitional allowance''), as provided in subsection (c).

(c) Factors determinative of transitional allowance

(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this subchapter and shall recognize—

(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this subchapter, and

(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this subchapter; and

(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this subchapter, less any salvage value of the hospital.

(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1395x(v)(1) of this title, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1395f(b) and 1395*l*(a)(2) of this title.

(d) Hearing to review determination

A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.

(Aug. 14, 1935, ch. 531, title XVIII, § 1884, as added Pub. L. 97–35, title XXI, § 2101(a)[(1)], Aug. 13, 1981, 95 Stat. 785; amended Pub. L. 97–248, title I, § 128(a)(6), Sept. 3, 1982, 96 Stat. 366.)

Editorial Notes

AMENDMENTS

1982—Subsec. (d). Pub. L. 97–248 redesignated second subsec. (c), relating to hearing to review determination, as subsec. (d).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was enacted by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE

Pub. L. 97–35, title XXI, § 2101(c), Aug. 13, 1981, 95 Stat. 787, provided that: ''The amendment made by subsection (a) [enacting this section and amending section 1396b of this title] shall apply only to services furnished by a hospital during any accounting year beginning on or after October 1, 1981.''

PAYMENTS TO PROMOTE CLOSURE AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

Pub. L. 98–369, div. B, title III, § 2353, July 18, 1984, 98 Stat. 1099, directed Secretary of Health and Human Services to carry out a study and report to Congress prior to Mar. 31, 1985, on modifications required in this section in order to conform the closure and conversion program authorized in that section to the prospective payment system under section 1395ww(d) of this title, so as to provide assistance to hospitals which may have particular problems in converting facilities (or parts thereof) from acute care to less intensive care or in closing facilities (or parts thereof), such report to include recommendations as to how, and whether, implementation of this section as modified may result in reductions in total hospital inpatient costs and total expenditures under this subchapter, and prohibited from implementing this section prior to Mar. 31, 1985.

ESTABLISHMENT AND EVALUATION OF TRANSITIONAL ALLOWANCES; REPORT AND RECOMMENDATIONS TO CONGRESS

Pub. L. 97–35, title XXI, § 2101(b), Aug. 13, 1981, 95 Stat. 786, prohibited Secretary of Health and Human Services from establishing under this section transitional allowances with respect to more than 50 hospitals prior to Jan. 1, 1984, and directed Secretary to evaluate effectiveness of program of transitional allowances established under this section and, not later than Jan. 1, 1983, report to Congress on such evaluation and include in such report such recommendations for such legislative changes as deemed appropriate.

§ 1395vv. Withholding payments from certain medicaid providers

(a) Adjustments by Secretary

The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1395cc of this title, and any person who has accepted payment on the basis of an assignment under section 1395u(b)(3)(B)(ii) of this title, where such institution or person—

(1) has (or previously had) in effect an agreement with a State agency to furnish medical care and services under a State plan approved under subchapter XIX, and

(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) Implementing regulations; notice, opportunity to be heard, etc.

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this subchapter which shall be treated as a setoff against overpayments under subchapter XIX, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XIX and to which the institution or person would otherwise be entitled under this subchapter.

(c) Payment to States of amounts recovered

Notwithstanding any other provision of this chapter, from the trust funds established under sections 1395i and 1395t of this title, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under subchapter XIX. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1885, as added Pub. L. 97–35, title XXI, § 2104, Aug. 13, 1981, 95 Stat. 788.)

§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term ''operating costs of inpatient hospital services'' includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, other capital-related costs (as defined by the Secretary for periods before October 1, 1987), for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant (as described in subsection (d)(5)(M)), or costs with respect to administering blood clotting factors to individuals with hemophilia. In applying the first sentence of this paragraph, the term ''other services related to the admission'' includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this subchapter that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—

(A) on the date of the patient's inpatient admission; or

(B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of such admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission.

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount,

whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Except as provided in subparagraph (E), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an ''eligible hospital'' means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term ''trended costs'' means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term ''expected costs'', with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before November 29, 1999, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

(3)(A) Except as provided in subparagraph (C) and succeeding subparagraphs, and in paragraph (7)(A)(ii), for purposes of this subsection, the term ''target amount'' means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the ''applicable percentage increase'' shall be—

(I) for fiscal year 1986, ½ percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55[1] for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year 2002, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years 2004 through 2006, subject to clause (vii), the market basket percentage increase for hospitals in all areas;[2] and

(XX) for each subsequent fiscal year, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the ''applicable percentage increase'' for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase,

(VI) for fiscal year 1998, is 0 percent,

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term ''market basket percentage increase'' means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the ''applicable percentage increase'' is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)—

(I) a hospital's ''update adjustment percentage'' for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the ''applicable reduction'' with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the most recent cost reporting period for which information is available—

[1] So in original. Probably should be followed by ''percentage point''.

[2] So in original. The semicolon probably should be a comma.

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)(I) For purposes of clause (i)(XIX) for fiscal years 2005 and 2006, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) For fiscal years 2005 and 2006, each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (*o*).

(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings.

(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(VII) The Secretary shall establish procedures for making information regarding measures submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(X) To the extent practicable, the Secretary shall, with input from consensus organizations

and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

(aa) physicians under section 1395w–4(k) of this title; and

(bb) other providers of services and suppliers under this subchapter.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(XII)(aa) With respect to a Hospital Consumer Assessment of Healthcare Providers and Systems survey (or a successor survey) conducted on or after January 1, 2020, such survey may not include questions about communication by hospital staff with an individual about such individual's pain unless such questions take into account, as applicable, whether an individual experiencing pain was informed about risks associated with the use of opioids and about non-opioid alternatives for the treatment of pain.

(bb) The Secretary shall not include on the Hospital Compare internet website any measures based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about such individual's pain.

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) (determined without regard to clause (viii), (xi), or (xii)) for such fiscal year shall be reduced by 33⅓ percent for fiscal year 2015, 66⅔ percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

(II) The Secretary may, on a case-by-case basis (and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016), exempt an eligible hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1395f(b)(3) of this title shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

(IV) For purposes of this clause, the term ''EHR reporting period'' means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.

(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.

(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point;

(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point;

(III) for fiscal year 2014, by 0.3 percentage point;

(IV) for each of fiscal years 2015 and 2016, by 0.2 percentage point; and

(V) for each of fiscal years 2017, 2018, and 2019, by 0.75 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraphs (I) and (L), the term ''target amount'' means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ''base cost reporting period'') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, and for discharges occurring on or after October 1, 1997, and before October 1, 2022, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), subject to subparagraph (K), the term ''target amount'' means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ''base cost reporting period'') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2022, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term ''target amount'' means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ''base cost reporting period'') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during

fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a ''qualified long-term care hospital'' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997, for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(I)(i) Subject to subparagraph (L), for cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital—

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the ''subsection (d)(5)(D)(i) amount'') and 25 percent of the rebased target amount (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subsection (d)(5)(D)(i) amount and 50 percent of the rebased target amount;

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subsection (d)(5)(D)(i) amount and 75 percent of the rebased target amount; and

(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the ''rebased target amount'' has the meaning given the term ''target amount'' in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the ''first cost reporting period'' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i) the 12-month cost reporting period beginning during fiscal year 2002; and

(II) any reference in such subparagraph to the ''first cost reporting period'' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.

(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

(ii) For purposes of this subparagraph, the term ''subparagraph (L) rebased target amount'' has the meaning given the term ''target amount'' in subparagraph (C), except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 2006;

(II) any reference in subparagraph (C)(i) to the ''first cost reporting period'' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after January 1, 2009; and

(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii), may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and nec-

essary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1986, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c) Payment in accordance with State hospital reimbursement control system; amount of payment; discontinuance of payments

(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this subchapter, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under subchapter XIX;

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this subchapter under such system will not exceed the amount of payments which would otherwise have been made under this subchapter not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1395mm(b) of this title) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the require-

ment of section 1395cc(a)(1)(G) of this title and the system provides for the exclusion of certain costs in accordance with section 1395y(a)(14) of this title (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this subchapter under such system must be less than the amount of payments which would otherwise have been made under this subchapter not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this subchapter for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this subchapter in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this subchapter for hospitals in the State which is less than the aggregate rate of increase in such costs under this subchapter for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of this subchapter has been approved on or before (and which is in effect as of) April 20, 1983, pursuant to section 1395b–1(a) of this title or section 222(a) of the Social Security Amendments of 1972.

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this subchapter, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this subchapter) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect

upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this subchapter to hospitals under the system in an amount equal to the amount by which the payment under this subchapter under such system for such period exceeded the amount of payments which would otherwise have been made under this subchapter not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a ''36-month period'' is deemed a reference to a ''48-month period'', and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to—

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same large urban or other area) as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term ''subsection (d) hospital'' means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days,

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990,[3] (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1395f(b) of this title, that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before August 5, 1997), that as of August 5, 1997, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that

[3] So in original. The comma probably should not appear.

at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1395f(b) of this title, that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of December 21, 2000, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(vi) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) (as in effect as of such date) shall continue to be so classified (or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification) notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the ''target percentage'' is 75 percent and the ''DRG percentage'' is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the ''target percentage'' is 50 percent and the ''DRG percentage'' is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the ''target percentage'' is 45 percent and the ''DRG percentage'' is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the ''target percentage'' is 25 percent and the ''DRG percentage'' is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the ''applicable combined adjusted DRG prospective payment rate'' for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subclauses (II) and (III) of subparagraph (B)(v) only, the term ''principal finding of neoplastic disease'' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Pre-

scription Drug, Improvement, and Modernization Act of 2003,

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1)[4] of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) COMPUTING URBAN AND RURAL AVERAGES.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term ''region'' means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term ''urban area'' means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term ''large urban area'' means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term ''rural area'' means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this subchapter) from hospitals in the same Metropolitan Statistical Area are made.

(E) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) MAINTAINING BUDGET NEUTRALITY.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS IN THE UNITED STATES AND IN EACH REGION.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine, for fiscal years before fiscal year 1997, a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a

[4] See References in Text note below.

fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—(i) For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

(D) COMPUTING DRG-SPECIFIC RATES FOR HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish, for fiscal years before fiscal year 1997, a regional DRG prospective payment rate for each region which is equal—

(i) for fiscal years before fiscal year 2004, for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(ii) for fiscal years before fiscal year 2004, for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—

(i) IN GENERAL.—Except as provided in clause (ii), (iii), or (iv), the Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act, and the amendments made by section 9831(a) of the American Rescue Plan Act of 2021 had not been enacted.

(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute ''62 percent'' for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.

(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

(II) FRONTIER STATE DEFINED.—In this clause, the term ''frontier State'' means a State in which at least 50 percent of the counties in the State are frontier counties.

(III) FRONTIER COUNTY DEFINED.—In this clause, the term ''frontier county'' means a county in which the population per square mile is less than 6.

(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).

(iv) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN ALL-URBAN STATES.—

(I) IN GENERAL.—For discharges occurring on or after October 1, 2021, the area wage index applicable under this subparagraph to any hospital in an all-urban State (as defined in subclause (IV)) may not be less than the minimum area wage index for the fiscal year for hospitals in that State, as established under subclause (II).

(II) MINIMUM AREA WAGE INDEX.—For purposes of subclause (I), the Secretary shall establish a minimum area wage index for a fiscal year for hospitals in each all-urban State using the methodology described in section 412.64(h)(4)(vi) of title 42, Code of Federal Regulations, as in effect for fiscal year 2018.

(III) WAIVING BUDGET NEUTRALITY.—Pursuant to the fifth sentence of clause (i), this clause shall not be applied in a budget neutral manner.

(IV) ALL-URBAN STATE DEFINED.—In this clause, the term ''all-urban State'' means a State in which there are no rural areas (as defined in paragraph (2)(D)) or a State

in which there are no hospitals classified as rural under this section.

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) or payments under paragraph (5)(M) (beginning with fiscal year 2021) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment or payments under paragraph (5)(M).

(iv)(I) For discharges occurring during the emergency period described in section 1320b–5(g)(1)(B) of this title, in the case of a discharge of an individual diagnosed with COVID–19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary.

(II) Any adjustment under subclause (I) shall not be taken into account in applying budget neutrality under clause (iii)[5]

(III) In the case of a State for which the Secretary has waived all or part of this section under the authority of section 1315a of this title, nothing in this section shall preclude such State from implementing an adjustment similar to the adjustment under subclause (I).

(D)(i) For discharges occurring on or after October 1, 2008, the diagnosis-related group to be assigned under this paragraph for a discharge described in clause (ii) shall be a diagnosis-related group that does not result in higher payment based on the presence of a secondary diagnosis code described in clause (iv).

(ii) A discharge described in this clause is a discharge which meets the following requirements:

(I) The discharge includes a condition identified by a diagnosis code selected under clause (iv) as a secondary diagnosis.

(II) But for clause (i), the discharge would have been classified to a diagnosis-related group that results in a higher payment based on the presence of a secondary diagnosis code selected under clause (iv).

(III) At the time of admission, no code selected under clause (iv) was present.

(iii) As part of the information required to be reported by a hospital with respect to a discharge of an individual in order for payment to be made under this subsection, for discharges occurring on or after October 1, 2007, the information shall include the secondary diagnosis of the individual at admission.

(iv) By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary):

(I) Cases described by such code have a high cost or high volume, or both, under this subchapter.

(II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis.

(III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary may from time to time revise (through addition or deletion of codes) the diagnosis codes selected under this clause so long as there are diagnosis codes associated with at least two conditions selected for discharges occurring during any fiscal year.

(v) In selecting and revising diagnosis codes under clause (iv), the Secretary shall consult with the Centers for Disease Control and Prevention and other appropriate entities.

(vi) Any change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall (except as payments under clause (i) are required to be reduced to

[5] So in original. Probably should be followed by a period.

take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1995 shall be 75 percent of the day outlier percentage for fiscal year 1994;

(II) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(III) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph, the term ''day outlier percentage'' means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to $c \times (((1+r)$ to the nth power $) - 1)$, where ''r'' is the ratio of the hospital's full-time equivalent interns and residents to beds and ''n'' equals .405. Subject to clause (ix), for discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, ''c'' is equal to 1.89;

(II) during fiscal year 1998, ''c'' is equal to 1.72;

(III) during fiscal year 1999, ''c'' is equal to 1.6;

(IV) during fiscal year 2000, ''c'' is equal to 1.47;

(V) during fiscal year 2001, ''c'' is equal to 1.54;

(VI) during fiscal year 2002, ''c'' is equal to 1.6;

(VII) on or after October 1, 2002, and before April 1, 2004, ''c'' is equal to 1.35;

(VIII) on or after April 1, 2004, and before October 1, 2004, ''c'' is equal to 1.47;

(IX) during fiscal year 2005, ''c'' is equal to 1.42;

(X) during fiscal year 2006, ''c'' is equal to 1.37;

(XI) during fiscal year 2007, ''c'' is equal to 1.32; and

(XII) on or after October 1, 2007, ''c'' is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), (h)(8), and (h)(9) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).

(vi) For purposes of clause (ii)—

(I) ''r'' may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

(viii) Rules similar to the rules of paragraphs (2)(F)(iv) and (4)(H) of subsection (h) shall apply for purposes of clauses (v) and (vi).

(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if ''c'' were equal to 0.66 with respect to such resident positions.

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(xi)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title; or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(xii) For discharges occurring on or after July 1, 2023, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(9), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i).

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this subchapter, the term ''sole community hospital'' means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997.

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1395i–4(d) of this title) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the

percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital ''serves a significantly disproportionate number of low income patients'' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also ''serves a significantly disproportionate number of low income patients'' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term ''disproportionate patient percentage'' means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, $(P-20.2)(.65) + 5.62$,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, $(P-20.2)(.7) + 5.62$,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, $(P-20.2)(.8) + 5.88$, and

(d) for discharges occurring on or after October 1, 1994, $(P-20.2)(.825) + 5.88$; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, $(P-15)(.6) + 2.5$,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, $(P-15)(.6) + 2.5$,[6]

(c) for discharges occurring on or after October 1, 1993, $(P-15)(.65) + 2.5$,

where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: $(P-30)(.6) + 4.0$, where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in

[6] So in original. Probably should be followed by ''and''.

accordance with the following formula: (P − 15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P − 15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P − 30)(.6) + 5.25,

where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P − 15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P − 15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where ''P'' is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2022, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2022, 50 percent (or 75 percent in the case of discharges occurring on or after October 1, 2006) of the amount by which the hospital's target amount for the cost reporting period or for discharges in the fiscal year (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term ''medicare-dependent, small rural hospital'' means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) that is located in—

(aa) a rural area; or

(bb) a State with no rural area (as defined in paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii),

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

Subclause (I)(bb) shall apply for purposes of payment under clause (ii) only for discharges of a hospital occurring on or after the effective date of a determination of medicare-dependent small rural hospital status made by the Secretary with respect to the hospital after February 9,

2018. For purposes of applying subclause (II) of paragraph (8)(E)(ii) under subclause (I)(bb), such subclause (II) shall be applied by inserting ''as of January 1, 2018,'' after ''such State'' each place it appears.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term ''transfer case'' (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term ''qualified discharge'' means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary);

(IV) for discharges occurring on or after October 1, 2018, is provided hospice care by a hospice program; or

(V) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV). The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post-discharge services not described in subclauses (I), (II), (III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). Such mechanism shall be modified to meet the requirements of clause (viii).

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate (applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved);

(II) provide for the collection of data with respect to the costs of a new medical service or technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

(III) provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing di-

agnosis-related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

(iii) For purposes of clause (ii)(II), the term ''inpatient hospital code'' means any code that is used with respect to inpatient hospital services for which payment may be made under this subsection and includes an alphanumeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification (''ICD–9–CM'') and its subsequent revisions.

(iv) For purposes of clause (ii)(III), the term ''additional payment'' means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new-technology group (described in subparagraph (L)), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h) of section 1395m of this title to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a ''new medical service or technology'' if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.

(M)(i) For cost reporting periods beginning on or after October 1, 2020, in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual during such a period, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis. The items included in such hematopoietic stem cell acquisition shall be specified by the Secretary through rulemaking.

(ii) For purposes of this subparagraph, the term ''allogeneic hematopoietic stem cell transplant'' means, with respect to an individual, the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal

year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judicial review under section 1395*oo* of this title or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii),

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4), including the selection and revision of codes under paragraph (4)(D), and

(C) the determination of whether services provided prior to a patient's inpatient admission are related to the admission (as described in subsection (a)(4)).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area's wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) the applicable Puerto Rico percentage (specified in subparagraph (E)) of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges,

(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(bb) such rate for hospitals located in other urban areas, and

(cc) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term ''subsection (d) Puerto Rico hospital'' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.

(ii) The Secretary shall reduce each of the average standardized amounts (or for fiscal year 2004 and thereafter, the average standardized amount) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)), and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv)(I) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E)(i) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute ''62 percent'' for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(E) For purposes of subparagraph (A), for discharges occurring—

(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent;

(iv) on or after October 1, 2004, and before January 1, 2016, the applicable Puerto Rico

percentage is 25 percent and the applicable Federal percentage is 75 percent; and

(v) on or after January 1, 2016, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the ''Board'').

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after December 19, 1989.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b[7] of title 5. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(v) Any decision of the Board to reclassify a subsection (d) hospital for purposes of the adjustment factor described in subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year thereafter shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the

[7] So in original. Probably should be section ''557(b)''.

same extent as such provisions apply to the Secretary with respect to subchapter II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS–18 of the General Schedule under section 5332 of title 5 for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, while away from their homes or regular places of business in the performance of services for the Board.

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term ''applicable discharge'' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+ Choice organization under part C.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) or (D) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2023 and subsequent fiscal years, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

(iii) In no case shall the applicable percentage increase exceed 25 percent.

(C) DEFINITIONS.—

(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term ''low-volume hospital'' means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011 through 2022, 15 road miles) from another subsection (d) hospital and has—

(I) with respect to each of fiscal years 2005 through 2010, less than 800 discharges during the fiscal year;

(II) with respect to each of fiscal years 2011 through 2018, less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A during the fiscal year or portion of fiscal year;

(III) with respect to each of fiscal years 2019 through 2022, less than 3,800 discharges during the fiscal year; and

(IV) with respect to fiscal year 2023 and each subsequent fiscal year, less than 800 discharges during the fiscal year.

(ii) DISCHARGE.—For purposes of subparagraphs (B) and (D) and clause (i), the term ''discharge'' means an inpatient acute care discharge of an individual regardless (except as provided in clause (i)(II) and subparagraph (D)(i)) of whether the individual is entitled to benefits under part A.

(iii) TREATMENT OF INDIAN HEALTH SERVICE AND NON-INDIAN HEALTH SERVICE FACILITIES.—For purposes of determining whether—

(I) a subsection (d) hospital of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25)), or

(II) a subsection (d) hospital other than a hospital of the Indian Health Service meets the mileage criterion under clause (i) with respect to fiscal year 2011 or a succeeding fiscal year, the Secretary shall apply the policy described in the regulation at part[8] 412.101(e) of title 42, Code of Federal Regulations (as in effect on March 23, 2018).

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 through 2022, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals—

(i) with respect to each of fiscal years 2011 through 2018, with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year or the portion of fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year or the portion of fiscal year or portion of fiscal year;[9] and

(ii) with respect to each of fiscal years 2019 through 2022, with 500 or fewer discharges in the fiscal year to 0 percent for low-volume hospitals with greater than 3,800 discharges in the fiscal year.

(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

(C) For purposes of this paragraph, the term ''higher wage index area'' means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1395cc(a)(1)(T) of this title, to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.

(e) Proportional adjustments in applicable percentage increases

(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts

[8] So in original. Probably should be ''section''.

[9] So in original.

which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title);

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.

(2) Repealed. Pub. L. 105–33, title IV, § 4022(b)(1)(A)(i), Aug. 5, 1997, 111 Stat. 354.

(3) Repealed. Pub. L. 109–432, div. B, title I, § 106(c)(2), Dec. 20, 2006, 120 Stat. 2983.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this subchapter under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(f) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this subchapter.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this subchapter).

(2) If the Secretary determines, based upon information supplied by a quality improvement organization under part B of subchapter XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1320a–7 of this title shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1320a–7(b)(13) of this title.

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1395x(v) of this title). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on August 10, 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this subchapter, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after April 20, 1983, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the ''applicable percentage'' is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this subchapter with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989, and

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)) or a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years

1998 through 2002 and that may be made under this subchapter with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this subchapter by 15 percent.

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception

The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) In general

Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) Freeze in update for fiscal years 1994 and 1995

For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) Floor for locality adjusted national average per resident amount

The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) Adjustment in rate of increase for hospitals with FTE approved amount above 140 percent of locality adjusted national average per resident amount

(I) Freeze for fiscal years 2001 and 2002 and 2004 through 2013

For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 percent decrease in update for fiscal years 2003, 2004, and 2005

For the cost reporting period beginning during fiscal year 2003, if the approved FTE resident amount for a hos-

pital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) No adjustment below 140 percent

In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) Determination of locality adjusted national average per resident amount

The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) Determining hospital single per resident amount

The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) Standardizing per resident amounts

The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1395w–4(e) of this title for 1999 for the fee schedule area in which the hospital is located.

(iii) Computing of weighted average

The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).

(iv) Computing national average per resident amount

The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(v) Adjusting for locality

The Secretary shall compute the product of—

(I) the national average per resident amount computed under clause (iv) for the hospital, and

(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

(vi) Computing locality adjusted amount

The locality adjusted national per resident amount for a hospital for—

(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.

(F) Treatment of certain hospitals

(i) In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(ii) In applying this subparagraph in the case of a hospital that trains residents and has not entered into a GME affiliation agreement (as defined by the Secretary for purposes of paragraph (4)(H)(ii)), on or after December 27, 2020, the Secretary shall not establish an FTE resident amount until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in an approved medical residency training program in a cost reporting period.

(iii) In applying this subparagraph for cost reporting periods beginning on or after December 27, 2020, in the case of a hospital that, as of such date, has an approved FTE resident amount based on the training in an approved medical residency program or programs of—

(I) less than 1.0 full-time-equivalent resident in any cost reporting period begin-

ning before October 1, 1997, as determined by the Secretary; or

(II) no more than 3.0 full-time-equivalent residents in any cost reporting period beginning on or after October 1, 1997, and before December 27, 2020, as determined by the Secretary,

in lieu of such FTE resident amount the Secretary shall, in accordance with the methodology described in section 413.77(e) of title 42 of the Code of Federal Regulations (or any successor regulation), establish a new FTE resident amount if the hospital trains at least 1.0 full-time-equivalent resident (in the case of a hospital described in subclause (I)) or more than 3.0 full-time-equivalent residents (in the case of a hospital described in subclause (II)) in a cost reporting period beginning on or after such date and before the date that is 5 years after such date.

(iv) For purposes of carrying out this subparagraph for cost reporting periods beginning on or after December 27, 2020, a hospital shall report full-time-equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents[9] in an approved medical residency training program or programs in such period.

(v) As appropriate, the Secretary may consider information from any cost reporting period necessary to establish a new FTE resident amount as described in clause (iii).

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term ''aggregate approved amount'' means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.

(C) Medicare patient load

As used in subparagraph (A), the term ''medicare patient load'' means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(D) Payment for managed care enrollees

(i) In general

For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) Applicable percentage

For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000,

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) Proportional reduction for nursing and allied health education

The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (*l*) for portions of cost reporting periods occurring in that year.

(iv) Special rule for hospitals under reimbursement system

The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a por-

tion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—

(i) effective for cost reporting periods beginning before July 1, 2010, all the time;[10] so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting; and

(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F) Limitation on number of residents in allopathic and osteopathic medicine

(i) In general

Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7), (8), and (9), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(ii) Counting primary care residents on certain approved leaves of absence in base year FTE count

(I) In general

In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) Limitation to 3 FTE residents for any hospital

The total number of individuals counted under subclause (I) for a hospital may

[10] So in original. The semicolon probably should not appear.

not exceed 3 full-time equivalent residents.

(G) Counting interns and residents for FY 1998 and subsequent years

(i) In general

For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) Adjustment for short periods

If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) Transition rule for 1998

In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) Special rules for application of subparagraphs (F) and (G)

(i) New facilities

(I) The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7), (8), and (9), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(II) In applying this clause in the case of a hospital that, on or after December 27, 2020, begins training residents in a new approved medical residency training program or programs (as defined by the Secretary), the Secretary shall not determine a limitation applicable to the hospital under subparagraph (F) until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in such new approved medical residency training program or programs in a cost reporting period.

(III) In applying this clause in the case of a hospital that, as of December 27, 2020, has a limitation under subparagraph (F), based on a cost reporting period beginning before October 1, 1997, of less than 1.0 full-time-equivalent resident, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital begins training at least 1.0 full-time-equivalent residents[9] in a program year beginning on or after such date and before the date that is 5 years after such date.

(IV) In applying this clause in the case of a hospital that, as of December 27, 2020, has a limitation under subparagraph (F), based on a cost reporting period beginning on or after October 1, 1997, and before such date, of no more than 3.0 full-time-equivalent residents, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital begins training more than 3.0 full-time-equivalent residents in a program year beginning on or after such date and before the date that is 5 years after such date.

(V) An adjustment to the limitation applicable to a hospital made pursuant to subclause (III) or (IV) shall be made in a manner consistent with the methodology, as appropriate, in section 413.79(e) of title 42, Code of Federal Regulations (or any successor regulation). As appropriate, the Secretary may consider information from any cost reporting periods necessary to make such an adjustment to the limitation.

(ii) Aggregation

The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) Data collection

The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) Training programs in rural areas

(I) Cost reporting periods beginning before October 1, 2022

For cost reporting periods beginning before October 1, 2022, in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(II) Cost reporting periods beginning on or after October 1, 2022

For cost reporting periods beginning on or after October 1, 2022, in the case of a hospital not located in a rural area that established or establishes a medical residency training program (or rural

tracks) in a rural area or establishes an accredited program where greater than 50 percent of the program occurs in a rural area, the Secretary shall[11] consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs with respect to such a program and, in accordance with such rules, adjust in an appropriate manner the limitation under subparagraph (F) for such hospital and each such hospital located in a rural area that participates in such a training.

(v) Special provider agreement

If an entity enters into a provider agreement pursuant to section 1395cc(a) of this title to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578—

(I) the limitation on the number of total full time equivalent residents under subparagraph (F) and clauses (v) and (vi)(I) of subsection (d)(5)(B) applicable to such provider shall be equal to the limitation applicable under such provisions to Provider No. 05–0578 for its cost reporting period ending on June 30, 2006; and

(II) the provisions of subparagraph (G) and subsection (d)(5)(B)(vi)(II) shall not be applicable to such provider for the first three cost reporting years in which such provider trains residents under any approved medical residency training program.

(vi) Redistribution of residency slots after a hospital closes

(I) In general

Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before March 23, 2010, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) Priority for hospitals in certain areas

Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) Requirement hospital likely to fill position within certain time period

The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

(IV) Limitation

The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(V) Administration

Chapter 35 of title 44 shall not apply to the implementation of this clause.

(J)[12] Treatment of certain nonprovider and didactic activities

Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) Treatment of certain other activities

In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) Definitions and special rules

As used in this subsection:

(A) Approved medical residency training program

The term ''approved medical residency training program'' means a residency or

[11] So in original. Probably should be followed by a comma.

[12] So in original. No subpar. (I) has been enacted.

other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) Consumer price index

The term ''consumer price index'' refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) Direct graduate medical education costs

The term ''direct graduate medical education costs'' means direct costs of approved educational activities for approved medical residency training programs.

(D) Foreign medical graduate

The term ''foreign medical graduate'' means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS examination

The term ''FMGEMS examination'' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term ''initial residency period'' means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) Period of board eligibility

(i) General rule

Subject to clauses (ii), (iii), (iv), and (v), the term ''period of board eligibility'' means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) Application of 1985–1986 directory

Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) Changes in period of board eligibility

On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) Special rule for certain primary care combined residency programs

(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(v) Child neurology training programs

In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) Primary care resident

The term ''primary care resident'' means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pe-

diatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) Resident

The term ''resident'' includes an intern or other participant in an approved medical residency training program.

(J) Adjustments for certain family practice residency programs

(i) In general

In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this subchapter or a State plan under subchapter XIX) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this subchapter if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this subchapter.

(ii) Additional requirements

A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

(K) Nonprovider setting that is primarily engaged in furnishing patient care

The term ''nonprovider setting that is primarily engaged in furnishing patient care'' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

(6) Incentive payment under plans for voluntary reduction in number of residents

(A) In general

In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this subchapter in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) Approval of plan applications

The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,[13]

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) Qualifying entity

For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) Residency reduction requirements

(i) Individual hospital applicants

In the case of a qualifying entity described in subparagraph (C)(i), the number

[13] So in original. The comma probably should be a semicolon.

of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(ii) Joint applicants

In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) Consortia

In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) Manner of reduction

The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) Entities providing assurance of increase in primary care residents

An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) "Base number of residents" defined

For purposes of this paragraph, the term ''base number of residents'' means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) Applicable hold harmless percentage

For purposes of subparagraph (A), the ''applicable hold harmless percentage'' for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

(ii) third such year, 75 percent,

(iii) fourth such year, 50 percent, and

(iv) fifth such year, 25 percent.

(F) Penalty for noncompliance

(i) In general

No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) Increase in number of residents in subsequent years

If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) Treatment of rotating residents

In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(7) Redistribution of unused resident positions

(A) Reduction in limit based on unused positions

(i) Programs subject to reduction

(I) In general

Except as provided in subclause (II), if a hospital's reference resident level

(specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(II) Exception for small rural hospitals

This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

(ii) Reference resident level

(I) In general

Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) Use of most recent accounting period to recognize expansion of existing programs

If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

(III) Expansions under newly approved programs

Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

(iii) Affiliation

The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

(B) Redistribution

(i) In general

The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) Considerations in redistribution

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

(iii) Priority for rural and small urban areas

In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

(iv) Limitation

In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(v) Application of locality adjusted national average per resident amount

With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

(vi) Construction

Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstra-

tion project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

(C) Resident level and limit defined

In this paragraph:

(i) Resident level

The term ''resident level'' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

(ii) Otherwise applicable resident limit

The term ''otherwise applicable resident limit'' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

(D) Adjustment based on settled cost report

In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued for such cost report between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.

(E) Judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise, with respect to determinations made under this paragraph, paragraph (8),[14] clause (i), (ii), (iii), or (v) of paragraph (2)(F), or clause (i) or (vi) of paragraph (4)(H).

(8) Distribution of additional residency positions

(A) Reductions in limit based on unused positions

(i) In general

Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) Exceptions

This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after March 23, 2010; or

(III) a hospital described in paragraph (4)(H)(v).

(B) Distribution

(i) In general

The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) Requirements

Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to March 23, 2010; and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

[14] So in original. Probably should be followed by ''paragraph (9),''. See 2020 Amendment notes below.

(iii) Redistribution of positions if hospital no longer meets certain requirements

In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) Considerations in redistribution

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(D) Priority for certain areas

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)[4]) as a health professional shortage area (as of March 23, 2010); to

(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) Reservation of positions for certain hospitals

(i) In general

Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) Exception if positions not redistributed by July 1, 2011

In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) Limitation

A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) Application of per resident amounts for primary care and nonprimary care

With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) Definitions

In this paragraph:

(i) Reference resident level

The term ''reference resident level'' means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before March 23, 2010) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) Resident level

The term ''resident level'' has the meaning given such term in paragraph (7)(C)(i).

(iii) Otherwise applicable resident limit

The term ''otherwise applicable resident limit'' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(I) Affiliation

The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(9) Distribution of additional residency positions

(A) Additional residency positions

(i) In general

For fiscal year 2023, and for each succeeding fiscal year until the aggregate number of full-time equivalent residency positions distributed under this paragraph

is equal to the aggregate number of such positions made available (as specified in clause (ii)(I)), the Secretary shall, subject to the succeeding provisions of this paragraph, increase the otherwise applicable resident limit for each qualifying hospital (as defined in subparagraph (F)) that submits a timely application under this subparagraph by such number as the Secretary may approve effective beginning July 1 of the fiscal year of the increase.

(ii) Number available for distribution

(I) Total number available

The aggregate number of such positions made available under this paragraph shall be equal to 1,000.

(II) Annual limit

The aggregate number of such positions so made available shall not exceed 200 for a fiscal year.

(iii) Process for distributing positions

(I) Rounds of applications

The Secretary shall initiate a separate round of applications for an increase under clause (i) for each fiscal year for which such an increase is to be provided.

(II) Timing

The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result of an increase in the otherwise applicable resident limit by January 31 of the fiscal year of the increase. Such increase shall be effective beginning July 1 of such fiscal year.

(B) Distribution

For purposes of providing an increase in the otherwise applicable resident limit under subparagraph (A), the following shall apply:

(i) Considerations in distribution

In determining for which qualifying hospitals such an increase is provided under subparagraph (A), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions made available under this paragraph within the first 5 training years beginning after the date the increase would be effective, as determined by the Secretary.

(ii) Minimum distribution for certain categories of hospitals

With respect to the aggregate number of such positions available for distribution under this paragraph, the Secretary shall distribute not less than 10 percent of such aggregate number to each of the following categories of hospitals:

(I) Hospitals that are located in a rural area (as defined in subsection (d)(2)(D)) or are treated as being located in a rural area pursuant to subsection (d)(8)(E).

(II) Hospitals in which the reference resident level of the hospital (as specified in subparagraph (F)(iii)) is greater than the otherwise applicable resident limit.

(III) Hospitals in States with—

(aa) new medical schools that received ''Candidate School'' status from the Liaison Committee on Medical Education or that received ''Pre-Accreditation'' status from the American Osteopathic Association Commission on Osteopathic College Accreditation on or after January 1, 2000, and that have achieved or continue to progress toward ''Full Accreditation'' status (as such term is defined by the Liaison Committee on Medical Education) or toward ''Accreditation'' status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation); or

(bb) additional locations and branch campuses established on or after January 1, 2000, by medical schools with ''Full Accreditation'' status (as such term is defined by the Liaison Committee on Medical Education) or ''Accreditation'' status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation).

(IV) Hospitals that serve areas designated as health professional shortage areas under section 254e(a)(1)(A) of this title, as determined by the Secretary.

(C) Limitations

(i) In general

A hospital may not receive more than 25 additional full-time equivalent residency positions under this paragraph.

(ii) Prohibition on distribution to hospitals without an increase agreement

No increase in the otherwise applicable resident limit of a hospital may be made under this paragraph unless such hospital agrees to increase the total number of full-time equivalent residency positions under the approved medical residency training program of such hospital by the number of such positions made available by such increase under this paragraph.

(D) Application of per resident amounts for primary care and nonprimary care

With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(E) Permitting facilities to apply aggregation rules

The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

(F) Definitions

In this paragraph:

(i) Otherwise applicable resident limit

The term ''otherwise applicable resident limit'' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), and (8)(B).

(ii) Qualifying hospital

The term ''qualifying hospital'' means a hospital described in any of subclauses (I) through (IV) of subparagraph (B)(ii).

(iii) Reference resident level

The term ''reference resident level'' means, with respect to a hospital, the resident level for the most recent cost reporting period of the hospital ending on or before December 27, 2020, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(iv) Resident level

The term ''resident level'' has the meaning given such term in paragraph (7)(C)(i).

(i) Avoiding duplicative payments to hospitals participating in rural demonstration programs

The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) Prospective payment for inpatient rehabilitation services

(1) Payment during transition period

(A) In general

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a ''rehabilitation facility''), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) Fully implemented system

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA and prospective payment percentages specified

For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the ''TEFRA percentage'' is 66⅔ percent and the ''prospective payment percentage'' is 33⅓ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the ''TEFRA percentage'' is 33⅓ percent and the ''prospective payment percentage'' is 66⅔ percent.

(D) Payment unit

For purposes of this subsection, the term ''payment unit'' means a discharge.

(E) Construction relating to transfer authority

Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) Election to apply full prospective payment system

A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) Patient case mix groups

(A) Establishment

The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a ''case mix group''), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) Weighting factors

For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within

that group compared to patients classified within other groups.

(C) Adjustments for case mix

(i) In general

The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this subchapter, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) Adjustment

Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) Data collection

The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) Payment rate

(A) In general

The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this subchapter. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this subchapter for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) Budget neutral rates

The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6) but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)) shall be equal to 98 percent for fiscal year 2001 and 100 percent for fiscal year 2002 of the amount of payments that would have been made under this subchapter during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) Increase factor

(i) In general

For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor subject to clauses (ii) and (iii). Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.

(ii) Productivity and other adjustment

Subject to clause (iii), after establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subpara-

graph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Special rule for fiscal year 2018

The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.

(D) Other adjustment

For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 and 2011, 0.25 percentage point;

(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point;

(iii) for fiscal year 2014, 0.3 percentage point;

(iv) for each of fiscal years 2015 and 2016, 0.2 percentage point; and

(v) for each of fiscal years 2017, 2018, and 2019, 0.75 percentage point.

(4) Outlier and special payments

(A) Outliers

(i) In general

The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) Payment based on marginal cost of care

The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) Total payments

The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) Adjustment

The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) Publication

The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) Area wage adjustment

The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) Quality reporting

(A) Reduction in update for failure to report

(i) In general

For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of subparagraphs (C)(iii) and (D) of paragraph (3), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) Submission of quality data

Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.

(F) Submission of additional data

(i) In general

For the fiscal year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395*lll* of this title), as applicable with respect to inpatient rehabilitation facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent fiscal year, in addition to such data on the quality measures described in subparagraph (C), each rehabilitation facility shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) Standardized patient assessment data

For fiscal year 2019 and each subsequent fiscal year, in addition to such data described in clause (i), each rehabilitation facility shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395*lll* of this title.

(iii) Submission

Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) Non-duplication

To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395*lll* of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) Payment to nonhospital providers

(1) In general

For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this subchapter.

(2) Qualified nonhospital providers

For purposes of this subsection, the term ''qualified nonhospital providers'' means—

(A) a Federally[15] qualified health center, as defined in section 1395x(aa)(4) of this title;

(B) a rural health clinic, as defined in section 1395x(aa)(2) of this title;

(C) Medicare+Choice organizations; and

(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(*l*) Payment for nursing and allied health education for managed care enrollees

(1) In general

For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1395x(v)(1) of this title.

(2) Payment amount

The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

[15] So in original. Probably should not be capitalized.

(A) Determination of managed care enrollee payment ratio for graduate medical education payments

The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) Application to fee-for-service nursing and allied health education payments

Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1395x(v) of this title for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(C) Application to hospital

The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1395mm of this title and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

(m) Prospective payment for long-term care hospitals

(1) Reference to establishment and implementation of system

For provisions related to the establishment and implementation of a prospective payment system for payments under this subchapter for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

(2) Update for rate year 2008

In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.

(3) Implementation for rate year 2010 and subsequent years

(A) In general

Subject to subparagraph (C), in implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

(B) Special rule

The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(C) Additional special rule

For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year, after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.

(4) Other adjustment

For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

(A) for rate year 2010, 0.25 percentage point;

(B) for rate year 2011, 0.50 percentage point;

(C) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(D) for rate year 2014, 0.3 percentage point;

(E) for each of rate years 2015 and 2016, 0.2 percentage point; and

(F) for each of rate years 2017, 2018, and 2019, 0.75 percentage point.

(5) Quality reporting

(A) Reduction in update for failure to report

(i) In general

Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in such annual update being

less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) Submission of quality data

Subject to subparagraph (G), for rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(iv) Additional quality measures

Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.

(E) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(F) Submission of additional data

(i) In general

For the rate year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395*lll* of this title), as applicable with respect to long-term care hospitals and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent rate year, in addition to the data on the quality measures described in subparagraph (C), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(vi)) shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) Standardized patient assessment data

For rate year 2019 and each subsequent rate year, in addition to such data described in clause (i), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(vi)) shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395*lll* of this title.

(iii) Submission

Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) Non-duplication

To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395*lll* of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(6) Application of site neutral IPPS payment rate in certain cases

(A) General application of site neutral IPPS payment amount for discharges failing to meet applicable criteria

(i) In general

For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraphs (C), (E), (F), and (G), payment under this subchapter to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

(ii) Exception for certain discharges meeting criteria

Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and

(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

(iii) Intensive care unit (ICU) criterion

(I) In general

The criterion specified in this clause (in this paragraph referred to as the ''ICU criterion''), for a discharge from a long-term care hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary.

(II) Determining ICU days

In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).

(iv) Ventilator criterion

The criterion specified in this clause (in this paragraph referred to as the ''ventilator criterion''), for a discharge from a long-term care hospital, is that—

(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS–LTC–DRG) based on the receipt of ventilator services of at least 96 hours.

(B) Applicable site neutral payment rate defined

(i) In general

In this paragraph, the term ''applicable site neutral payment rate'' means—

(I) for discharges in cost reporting periods beginning during fiscal years 2016 through 2019, the blended payment rate specified in clause (iii); and

(II) for discharges in cost reporting periods beginning during fiscal year 2020 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

(ii) Site neutral payment rate defined

Subject to clause (iv), in this paragraph, the term ''site neutral payment rate'' means the lower of—

(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

(II) 100 percent of the estimated cost for the services involved.

(iii) Blended payment rate

The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—

(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

(iv) Adjustment

For each of fiscal years 2018 through 2026, the amount that would otherwise apply under clause (ii)(I) for the year (determined without regard to this clause) shall be reduced by 4.6 percent.

(C) Limiting payment for all hospital discharges to site neutral payment rate for hospitals failing to meet applicable LTCH discharge thresholds

(i) Notice of LTCH discharge payment percentage

For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

(ii) Limitation

For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—

(I) the Secretary shall inform the hospital of such fact; and

(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

(iii) Process for reinstatement

The Secretary shall establish a process whereby a long-term care hospital may seek to and have the provisions of subclause (II) of clause (ii) discontinued with respect to that hospital.

(iv) LTCH discharge payment percentage

In this subparagraph, the term ''LTCH discharge payment percentage'' means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

(I) the number of Medicare fee-for-service discharges for such hospital and period for which payment is not made at the site neutral payment rate, to

(II) the total number of Medicare fee-for-service discharges for such hospital and period.

(D) Inclusion of subsection (d) Puerto Rico hospitals

In this paragraph, any reference in this paragraph to a subsection (d) hospital shall

be deemed to include a reference to a subsection (d) Puerto Rico hospital.

(E) Temporary exception for certain severe wound discharges from certain long-term care hospitals

(i) In general

In the case of a discharge occurring prior to January 1, 2017, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital that is—

(aa) identified by the last sentence of subsection (d)(1)(B); and

(bb) located in a rural area (as defined in subsection (d)(2)(D)) or treated as being so located pursuant to subsection (d)(8)(E); and

(II) the individual discharged has a severe wound.

(ii) Severe wound defined

In this subparagraph, the term ''severe wound'' means a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity, as identified in the claim from the long-term care hospital.

(F) Temporary exception for certain spinal cord specialty hospitals

For discharges in cost reporting periods beginning during fiscal years 2018 and 2019, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge is from a long-term care hospital that meets each of the following requirements:

(i) Not-for-profit

The long-term care hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data.

(ii) Primarily providing treatment for catastrophic spinal cord or acquired brain injuries or other paralyzing neuromuscular conditions

Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under this section, at least 50 percent were classified under MS–LTCH–DRGs 28, 29, 52, 57, 551, 573, and 963.

(iii) Significant out-of-state admissions

(I) In general

The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under this subchapter and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States, determined by the States of residency of such inpatients and based on such data submitted by the hospital to the Secretary as the Secretary may require.

(II) Implementation

Notwithstanding any other provision of law, the Secretary may implement subclause (I) by program instruction or otherwise.

(III) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 shall not apply to data collected under this clause.

(G) Additional temporary exception for certain severe wound discharges from certain long-term care hospitals

(i) In general

For a discharge occurring in a cost reporting period beginning during fiscal year 2018, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital identified by the last sentence of subsection (d)(1)(B);

(II) is classified under MS–LTCH–DRG 602, 603, 539, or 540; and

(III) is with respect to an individual treated by a long-term care hospital for a severe wound.

(ii) Severe wound defined

In this subparagraph, the term ''severe wound'' means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the long-term care hospital.

(iii) Wound defined

In this subparagraph, the term ''wound'' means an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(7) Treatment of high cost outlier payments

(A) Adjustment to the standard Federal payment rate for estimated high cost outlier payments

Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(B) Limitation on high cost outlier payment amounts

Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(C) Waiver of budget neutrality

Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

(D) No effect on site neutral high cost outlier payment rate

This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).

(n) Incentives for adoption and meaningful use of certified EHR technology

(1) In general

Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1395i of this title, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

(2) Payment amount

(A) In general

Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

(i) Initial amount

The sum of—

(I) the base amount specified in subparagraph (B); plus

(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

(ii) Medicare share

The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year.

(iii) Transition factor

The transition factor specified in subparagraph (E) for the eligible hospital for the payment year.

(B) Base amount

The base amount specified in this subparagraph is $2,000,000.

(C) Discharge related amount

The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) For the first through 1,149th discharge, $0.

(ii) For the 1,150th through the 23,000th discharge, $200.

(iii) For any discharge greater than the 23,000th, $0.

(D) Medicare share

The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—

(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—

(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

(ii) the denominator of which is the product of—

(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this subchapter), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

(E) Transition factor specified

(i) In general

Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

(I) For the first payment year for such hospital, 1.

(II) For the second payment year for such hospital, ¾.

(III) For the third payment year for such hospital, ½.

(IV) For the fourth payment year for such hospital, ¼.

(V) For any succeeding payment year for such hospital, 0.

(ii) Phase down for eligible hospitals first adopting EHR after 2013

If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

(F) Form of payment

The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(G) Payment year defined

(i) In general

For purposes of this subsection, the term ''payment year'' means a fiscal year beginning with fiscal year 2011.

(ii) First, second, etc. payment year

The term ''first payment year'' means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms ''second payment year'', ''third payment year'', and ''fourth payment year'' mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

(3) Meaningful EHR user

(A) In general

For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

(i) Meaningful use of certified EHR technology

The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

(ii) Information exchange

The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) Limitations

The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) Coordination of reporting of information

In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

(C) Demonstration of meaningful use of certified EHR technology and information exchange

(i) In general

An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of subparagraph (A).

(4) Application

(A) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

(iii) the specification of EHR reporting periods under paragraph (6)(B)[16] and the selection of the form of payment under paragraph (2)(F).

(B) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1395f(*l*) of this title applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

(5) Certified EHR technology defined

The term ''certified EHR technology'' has the meaning given such term in section 1395w–4(*o*)(4) of this title.

(6) Definitions

For purposes of this subsection:

(A) EHR reporting period

The term ''EHR reporting period'' means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(B) Eligible hospital

The term ''eligible hospital'' means a hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital.

(*o*) Hospital value-based purchasing program

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ''Program'') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

(B) Program to begin in fiscal year 2013

The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) Applicability of Program to hospitals

(i) In general

For purposes of this subsection, subject to clause (ii), the term ''hospital'' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

(ii) Exclusions

The term ''hospital'' shall not include, with respect to a fiscal year, a hospital—

(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

(iii) Independent analysis

For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

(iv) Exemption

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary de-

[16] So in original. Probably should be ''(6)(A)''.

scribing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(2) Measures

(A) In general

The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

(B) Requirements

(i) For fiscal year 2013

For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

(I) Conditions or procedures

Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as ''Surgical Infection Prevention'' for discharges occurring before July 2006).

(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

(II) HCAHPS

Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

(ii) Inclusion of efficiency measures

For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ''Medicare spending per beneficiary''. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(iii) HCAHPS pain questions

The Secretary may not include under subparagraph (A) a measure that is based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about the individual's pain.

(C) Limitations

(i) Time requirement for prior reporting and notice

The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(ii) Measure not applicable unless hospital furnishes services appropriate to the measure

A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

(D) Replacing measures

Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

(3) Performance standards

(A) Establishment

The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

(B) Achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) Timing

The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) Considerations in establishing standards

In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(ii) historical performance standards;

(iii) improvement rates; and

(iv) the opportunity for continued improvement.

(4) Performance period

For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

(5) Hospital performance score

(A) In general

Subject to subparagraph (B), the Secretary shall develop a methodology for assessing

the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ''hospital performance score'') for each hospital for each performance period.

(B) Application

(i) Appropriate distribution

The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

(ii) Higher of achievement or improvement

The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(iii) Weights

The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) No minimum performance standard

The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

(v) Reflection of measures applicable to the hospital

The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) Calculation of value-based incentive payments

(A) In general

In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

(B) Value-based incentive payment amount

The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) Value-based incentive payment percentage

(i) In general

The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) Requirements

In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

(7) Funding for value-based incentive payments

(A) Amount

The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

(B) Adjustment to payments

(i) In general

The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

(ii) No effect on other payments

Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

(C) Applicable percent defined

For purposes of subparagraph (B), the term ''applicable percent'' means—

(i) with respect to fiscal year 2013, 1.0 percent;

(ii) with respect to fiscal year 2014, 1.25 percent;

(iii) with respect to fiscal year 2015, 1.5 percent;

(iv) with respect to fiscal year 2016, 1.75 percent; and

(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) Base operating DRG payment amount defined

(i) In general

Except as provided in clause (ii), in this subsection, the term ''base operating DRG payment amount'' means, with respect to a hospital for a fiscal year—

(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

(II) any portion of such payment amount that is attributable to—

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

(bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) Special rules for certain hospitals

(I) Sole community hospitals and medicare-dependent, small rural hospitals

In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

(II) Hospitals paid under section 1395f

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the term ''base operating DRG payment amount'' means the payment amount under such section.

(8) Announcement of net result of adjustments

Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

(9) No effect in subsequent fiscal years

The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) Public reporting

(A) Hospital specific information

(i) In general

The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(I) the performance of the hospital with respect to each measure that applies to the hospital;

(II) the performance of the hospital with respect to each condition or procedure; and

(III) the hospital performance score assessing the total performance of the hospital.

(ii) Opportunity to review and submit corrections

The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

(iii) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(B) Aggregate information

The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

(11) Implementation

(A) Appeals

The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

(B) Limitation on review

Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

(v) The methodology developed under paragraph (5) that is used to calculate hos-

pital performance scores and the calculation of such scores.

(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

(C) Consultation with small hospitals

The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

(12) Promulgation of regulations

The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).

(p) Adjustment to hospital payments for hospital acquired conditions

(1) In general

In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this subchapter, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1395f(b)(3) of this title, as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1395f(b)(3) of this title (determined after the application of subsections (*o*) and (q) and section 1395f(*l*)(4) of this title but without regard to this subsection).

(2) Applicable hospitals

(A) In general

For purposes of this subsection, the term ''applicable hospital'' means a subsection (d) hospital that meets the criteria described in subparagraph (B).

(B) Criteria described

(i) In general

The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

(ii) Risk adjustment

In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

(C) Exemption

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(3) Hospital acquired conditions

For purposes of this subsection, the term ''hospital acquired condition'' means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

(4) Applicable period

In this subsection, the term ''applicable period'' means, with respect to a fiscal year, a period specified by the Secretary.

(5) Reporting to hospitals

Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

(6) Reporting hospital specific information

(A) In general

The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

(B) Opportunity to review and submit corrections

The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

(C) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(A) The criteria described in paragraph (2)(A).

(B) The specification of hospital acquired conditions under paragraph (3).

(C) The specification of the applicable period under paragraph (4).

(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).

(q) Hospital readmissions reduction program

(1) In general

With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under

subsection (d) (or section 1395f(b)(3) of this title, as the case may be) in an amount equal to the product of—

(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

(2) Base operating DRG payment amount defined

(A) In general

Except as provided in subparagraph (B), in this subsection, the term ''base operating DRG payment amount'' means, with respect to a hospital for a fiscal year—

(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (*o*)) for a discharge if this subsection did not apply; reduced by

(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

(B) Special rules for certain hospitals

(i) Sole community hospitals and medicare-dependent, small rural hospitals

In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

(ii) Hospitals paid under section 1395f of this title

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

(3) Adjustment factor

(A) In general

For purposes of paragraph (1), subject to subparagraph (D), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

(ii) the floor adjustment factor specified in subparagraph (C).

(B) Ratio

The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

(C) Floor adjustment factor

For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

(i) fiscal year 2013 is 0.99;

(ii) fiscal year 2014 is 0.98; or

(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

(D) Transitional adjustment for dual eligibles

(i) In general

In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after fiscal year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

(ii) Defining groups

For purposes of this subparagraph, the Secretary shall define groups of hospitals, based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, and who are full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

(iii) Minimizing reporting burden on hospitals

In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

(iv) Budget neutral design methodology

The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.

(E) Changes in risk adjustment

(i) Consideration of recommendations in IMPACT reports

The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of

2014 (Public Law 113–185; 42 U.S.C. 1395*lll* note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.

(ii) Consideration of exclusion of patient cases based on V or other appropriate codes

In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.

(iii) Removal of certain readmissions

In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.

(4) Aggregate payments, excess readmission ratio defined

For purposes of this subsection:

(A) Aggregate payments for excess readmissions

The term ''aggregate payments for excess readmissions'' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

(ii) the number of admissions for such condition for such hospital for such applicable period; and

(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

(B) Aggregate payments for all discharges

The term ''aggregate payments for all discharges'' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

(C) Excess readmission ratio

(i) In general

Subject to clause (ii), the term ''excess readmissions ratio'' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

(ii) Exclusion of certain readmissions

For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

(5) Definitions

For purposes of this subsection:

(A) Applicable condition

The term ''applicable condition'' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this subchapter (or other criteria specified by the Secretary); and

(ii) measures of such readmissions—

(I) have been endorsed by the entity with a contract under section 1395aaa(a) of this title; and

(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

(B) Expansion of applicable conditions

Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of March 23, 2010, to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Applicable hospital

The term ''applicable hospital'' means a subsection (d) hospital or a hospital that is paid under section 1395f(b)(3) of this title, as the case may be.

(D) Applicable period

The term ''applicable period'' means, with respect to a fiscal year, such period as the Secretary shall specify.

(E) Readmission

The term ''readmission'' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

(6) Reporting hospital specific information

(A) In general

The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

(B) Opportunity to review and submit corrections

The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

(C) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(A) The determination of base operating DRG payment amounts.

(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

(C) The measures of readmissions as described in paragraph (5)(A)(ii).

(8) Readmission rates for all patients

(A) Calculation of readmission

The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this subchapter and posted on the CMS Hospital Compare website.

(B) Posting of hospital specific all patient readmission rates

The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) Hospital submission of all patient data

(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

(D) Definitions

For purposes of this paragraph:

(i) The term ''all patients'' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term ''specified hospital'' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.

(r) Adjustments to medicare DSH payments

(1) Empirically justified DSH payments

For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) Additional payment

In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) Factor one

A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) Factor two

(i) Fiscal years 2014, 2015, 2016, and 2017

For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated),

minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 and subsequent years

For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) Factor three

A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

(3) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

(B) Any period selected by the Secretary for such purposes.

(s) Prospective payment for psychiatric hospitals

(1) Reference to establishment and implementation of system

For provisions related to the establishment and implementation of a prospective payment system for payments under this subchapter for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) Implementation for rate year beginning in 2010 and subsequent rate years

(A) In general

In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

(B) Special rule

The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(3) Other adjustment

For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

(A) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point;

(B) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(C) for the rate year beginning in 2014, 0.3 percentage point;

(D) for each of the rate years beginning in 2015 and 2016, 0.2 percentage point; and

(E) for each of the rate years beginning in 2017, 2018, and 2019, 0.75 percentage point.

(4) Quality reporting

(A) Reduction in update for failure to report

(i) In general

Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) Submission of quality data

For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(E) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.

(t) Relating similar inpatient and outpatient hospital services

(1) Development of HCPCS version of MS–DRG codes

Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that are similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD–10–PCS code.

(2) Coverage of surgical MS–DRGs

In carrying out paragraph (1), the Secretary shall develop HCPCS versions of MS–DRG codes for not fewer than 10 surgical MS–DRGs.

(3) Publication and dissemination of the HCPCS versions of MS–DRGs

(A) In general

The Secretary shall develop a HCPCS MS–DRG definitions manual and software that is similar to the definitions manual and software for ICD–10–PCS codes for such MS–DRGs. The Secretary shall post the HCPCS MS–DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS–DRG definitions manual and software shall be in the public domain and available for use and redistribution without charge.

(B) Use of previous analysis done by MedPAC

In developing the HCPCS MS–DRG definitions manual and software under subparagraph (A), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into inpatient surgical MS–DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its ''Medicare and the Health Care Delivery System'' report submitted to Congress in June 2015.

(4) Definition and reference

In this subsection:

(A) HCPCS

The term ''HCPCS'' means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

(B) ICD–10–PCS

The term ''ICD–10–PCS'' means the International Classification of Diseases, 10th Revision, Procedure Coding System, and in-

cludes any subsequent revision of such International Classification of Diseases, Procedure Coding System.

(Aug. 14, 1935, ch. 531, title XVIII, § 1886, as added and amended Pub. L. 97–248, title I, §§ 101(a)(1), 110, Sept. 3, 1982, 96 Stat. 331, 339; Pub. L. 97–448, title III, § 309(b)(13)–(15), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, § 601(a)(1), (2), (b), (c), (d)(2), (e), Apr. 20, 1983, 97 Stat. 149, 150, 152; Pub. L. 98–369, div. B, title III, §§ 2307(b)(1), 2310(a), 2311(a)–(c), 2312(a), (b), 2313(a), (b), (d), 2315(a)–(c), 2354(b)(42)–(44), July 18, 1984, 98 Stat. 1073, 1075–1080, 1102; Pub. L. 98–617, § 3(b)(9), Nov. 8, 1984, 98 Stat. 3296; Pub. L. 99–272, title IX, §§ 9101(b), (c), 9102(a)–(c), 9104(a), (b), 9105(a)–(c), 9106(a), 9107(a), 9109(a), 9111(a), 9127(a), 9202(a), Apr. 7, 1986, 100 Stat. 153–155, 157–162, 170, 171; Pub. L. 99–349, title II, § 206, July 2, 1986, 100 Stat. 749; Pub. L. 99–509, title IX, §§ 9302(a)(1), (2), (b)(1), (c), (d)(1)(A), (e), 9303, 9304(a)–(c), 9306(a)–(c), 9307(c)(1), 9314(a), 9320(g), 9321(e)(2), Oct. 21, 1986, 100 Stat. 1982–1985, 1988, 1995, 2005, 2015, 2018; Pub. L. 99–514, § 2, title XVIII, § 1895(b)(1)(A)–(C), (2)(A)–(C), (3), (9), Oct. 22, 1986, 100 Stat. 2095, 2931–2933; Pub. L. 100–93, § 8(c)(4), Aug. 18, 1987, 101 Stat. 693; Pub. L. 100–203, title IV, §§ 4002(a)–(f)(1), 4003(a)–(c), 4004(a), 4005(a)(1), (c)(1), (d)(1)(A), 4006(a)–(b)(2), 4007(b)(1), 4009(d)(1), (j)(1)–(6)(B), 4083(b)(1), Dec. 22, 1987, 101 Stat. 1330–42 to 1330–44, 1330–46, 1330–47, 1330–49, 1330–52, 1330–53, 1330–57 to 1330–59, 1330–129, as amended Pub. L. 100–360, title IV, § 411(b)(1)(E), (3), (4)(C)(i), (5)(B), (6)(B), (8)(B), July 1, 1988, 102 Stat. 769, 770, 772; Pub. L. 100–360, title IV, § 411(b)(1)(A)–(D), (F)–(H)(i), (4)(A), (B), (5)(A), July 1, 1988, 102 Stat. 768–770; Pub. L. 100–485, title VI, § 608(d)(18)(A), (B), Oct. 13, 1988, 102 Stat. 2418; Pub. L. 100–647, title I, § 1018(r)(1), title VIII, §§ 8401, 8403(a), Nov. 10, 1988, 102 Stat. 3586, 3798; Pub. L. 101–234, title III, § 301(b)(3), (c)(3), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101–239, title VI, §§ 6002, 6003(a)(1), (b)–(c)(3), (e)(1), (2)(B)–(E), (f), (g)(2), (4)–(h)(4), (6), 6004(a)(1), (2), (b)(1), 6011(a), 6015(a), 6022, Dec. 19, 1989, 103 Stat. 2140–2144, 2151, 2154–2157, 2159–2161, 2164, 2167; Pub. L. 101–403, title I, § 115(b)(1), Oct. 1, 1990, 104 Stat. 870; Pub. L. 101–508, title IV, §§ 4001, 4002(a)(1), (b)(1)–(4), (c)(1), (2), (e)(1), (g)(1), (2), (h)(1)(A), (2)(B), 4003(a), 4005(a)(1), (c)(1)(B), (2), 4008(f)(1), (m)(2)(A), Nov. 5, 1990, 104 Stat. 1388–31 to 1388–38, 1388–40, 1388–42, 1388–45, 1388–53; Pub. L. 103–66, title XIII, §§ 13501(a), (b)(1), (c), (e)(1), (f), 13502, 13506, 13563(a), (b)(1), (c)(1), Aug. 10, 1993, 107 Stat. 572, 574, 575, 577, 579, 605; Pub. L. 103–432, title I, §§ 101(a)(1), (b), (c), 102(b)(1)(B), 105, 108–110(a), (c), 153(a), Oct. 31, 1994, 108 Stat. 4400–4402, 4405, 4407, 4408, 4437; Pub. L. 105–33, title IV, §§ 4022(b)(1)(A), 4201(c)(1), (4), 4202(a), 4204(a)(1), (2), 4401(a), 4402, 4403(a), 4405(a)–(c), 4406, 4407, 4411–4415(c), 4416, 4417(a)(1), (b)(1), 4418(a), 4419(a)(1), 4421(a), (b), 4621–4626(a), 4627(a), 4644(a)(1), (b)(1), (c)(1), Aug. 5, 1997, 111 Stat. 354, 373–375, 397, 398, 400, 401, 403–410, 413, 475–480, 483, 488; Pub. L. 106–113, div. B, § 1000(a)(6) [title I, §§ 111(a), (c), 112(a), 121(a), 122, 125(a), title III, §§ 311, 312(a), 321(b), (e), (f), (h), (k)(15)–(17), title IV, §§ 401(a), 402(a), 404(a), (b)(1), 405–407(a)(2), (b)(1), (2), (c)(1), title V, § 541], Nov. 29, 1999, 113 Stat. 1536, 1501A–329 to 1501A–332, 1501A–362 to 150A–366, 1501A–368, 1501A–369, 1501A–372 to 1501A–374, 1501A–391; Pub. L. 106–554, § 1(a)(4) [div. B, title I, § 152(a), (b)], § 1(a)(6) [title II, §§ 211, 212(a), 213(a), title III, §§ 301(a), (e)(1), 302(a), (c), (d), 303(a), (c), (d)(1), 304(a), (c)(2), 305(a), (b), 307(a)(1), title V, §§ 511, 512(a), 533(b)(1), (3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–251, 2763A–252, 2763A–483, 2763A–485, 2763A–491 to 2763A–496, 2763A–533, 2763A–548, 2763A–550; Pub. L. 108–173, title IV, §§ 401(a)–(c), 402, 403, 406, 407(a), 422(a), (b)(1), title V, §§ 501(a), (b), 502(a), (b), 503(a)–(d)(1), 504, 505(a), title VII, §§ 711, 736(a)(9), (15), (c)(6), Dec. 8, 2003, 117 Stat. 2262–2265, 2269, 2270, 2284, 2286, 2289–2293, 2340, 2355, 2356; Pub. L. 109–171, title V, §§ 5001(a), (c), 5002(a), 5003(a)(1), (2)(A), (b)–(d), Feb. 8, 2006, 120 Stat. 28, 30–32; Pub. L. 109–432, div. B, title I, §§ 106(c), 109(a)(2), title II, § 205(b)(1), Dec. 20, 2006, 120 Stat. 2983, 2985, 2989; Pub. L. 110–161, div. G, title II, § 225(a), (b)(1), Dec. 26, 2007, 121 Stat. 2189; Pub. L. 110–173, title I, §§ 114(e)(1), 115(a)(1), Dec. 29, 2007, 121 Stat. 2504, 2506; Pub. L. 110–275, title I, § 122, July 15, 2008, 122 Stat. 2514; Pub. L. 111–5, div. B, title IV, § 4102(a)(1), (b)(1), Feb. 17, 2009, 123 Stat. 477, 482; Pub. L. 111–148, title III, §§ 3001(a)(1)–(3), 3004(a), (b), 3008(a), 3025(a), 3124(a), (b)(1), 3125, 3133, 3401(a), (c), (d), (f), title V, §§ 5503(a), (b), 5504(a), (b), 5505(a), (b), 5506(a), (b), (e), title X, §§ 10309, 10314, 10316, 10319(a)–(c), (e), 10322(a), 10324(a), 10335, Mar. 23, 2010, 124 Stat. 353–360, 368, 369, 376, 408, 424, 425, 432, 480–483, 655, 658–663, 942, 944, 946, 948, 949, 952, 959, 974; Pub. L. 111–152, title I, §§ 1104–1105(d), Mar. 30, 2010, 124 Stat. 1047, 1048; Pub. L. 111–192, title I, § 102(a), June 25, 2010, 124 Stat. 1281; Pub. L. 111–309, title II, § 203, Dec. 15, 2010, 124 Stat. 3289; Pub. L. 112–40, title II, § 261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–240, title VI, §§ 605–606(b)(1), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §§ 1105–1106(b)(1), title II, § 1206(a)(1), (c), Dec. 26, 2013, 127 Stat. 1197, 1200, 1204; Pub. L. 113–93, title I, §§ 105–106(b)(1), 112(a), Apr. 1, 2014, 128 Stat. 1042, 1044; Pub. L. 113–185, § 2(c)(2), (3), Oct. 6, 2014, 128 Stat. 1963, 1964; Pub. L. 114–10, title I, § 106(b)(2)(B), title II, §§ 204–205(b)(1), title IV, § 411(b), (e), Apr. 16, 2015, 129 Stat. 139, 144, 145, 161, 162; Pub. L. 114–113, div. H, title II, § 231, div. O, title VI, §§ 601–602(b)(1), Dec. 18, 2015, 129 Stat. 2626, 3023, 3024; Pub. L. 114–115, § 4(b), Dec. 28, 2015, 129 Stat. 3133; Pub. L. 114–255, div. A, title IV, § 4002(b)(2), div. C, title XV, §§ 15001—15002(b), 15004(b), 15008(a), (b), (d)(2), 15009(a), 15010(a), Dec. 13, 2016, 130 Stat. 1161, 1315—1317, 1319, 1321–1323; Pub. L. 115–123, div. E, title II, §§ 50204(a), 50205(a), (b)(1), title IV, § 50413, title X, § 51005, title XII, § 53109(a), Feb. 9, 2018, 132 Stat. 181–183, 221, 296, 303; Pub. L. 115–141, div. G, title IV, § 429, Mar. 23, 2018, 132 Stat. 693; Pub. L. 115–271, title VI, § 6104, Oct. 24, 2018, 132 Stat. 4006; Pub. L. 116–94, div. N, title I, § 108, Dec. 20, 2019, 133 Stat. 3102; Pub. L. 116–136, div. A, title III, § 3710(a), Mar. 27, 2020, 134 Stat. 422; Pub. L. 116–260, div. CC, title I, §§ 126(a)–(c), 127, 131(a)–(c), Dec. 27, 2020, 134 Stat. 2967–2970, 2974, 2976; Pub. L. 117–2, title IX, § 9831, Mar. 11, 2021, 135 Stat. 221.)

Editorial Notes

REFERENCES IN TEXT

Section 5001(b) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(viii)(I), is section 5001(b) of Pub. L. 109–171, which is set out below.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsecs. (b)(3)(B)(viii)(IV) and (d)(2)(C)(i), is Pub. L. 108–173, Dec. 8, 2003, 117 Stat. 2066. Section 238(b) of the Act is set out as a note under section 1395*ll* of this title. Section 402(a) of the Act, which amended this section, does not contain a par. (1). Section 403(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b)(6), is classified generally to Title 26, Internal Revenue Code.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (c)(4)(B), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

The effective date of such clause (vi), referred to in concluding provisions of subsec. (d)(1)(B), probably means the date of enactment of Pub. L. 114–255, which redesignated subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) of subsec. (d)(1)(B), and which was approved Dec. 13, 2016.

Section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(2)(C)(i), is section 9104(a) of Pub. L. 99–272, which amended subsec. (d)(5)(B) of this section.

Section 4621(a)(1) of the Balanced Budget Act of 1997, referred to in subsec. (d)(2)(C)(i), is section 4621(a)(1) of Pub. L. 105–33, which amended subsec. (d)(5)(B)(ii) of this section.

Section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (d)(2)(C)(i), is section 1000(a)(6) [title I, §111] of Pub. L. 106–113, which amended this section and enacted provisions set out as a note under this section.

Section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(i), is section 1(a)(6) [title III, §302] of Pub. L. 106–554, which amended this section and enacted provisions set out as a note under this section.

Section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (d)(2)(C)(iv), is section 6003(c) of Pub. L. 101–239, which amended this section and enacted provisions set out below.

Section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(2)(C)(iv), is section 4002(b) of Pub. L. 101–508, which amended this section and enacted provisions set out below.

Section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(iv), is section 1(a)(6) [title III, §303] of Pub. L. 106–554, which amended this section and enacted provisions set out as notes under this section.

Section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(3)(C)(ii), is section 9104 of Pub. L. 99–272, which amended subsec. (d)(2)(C)(i), (3)(C), (D)(i)(I), (ii)(I), and (5)(B) of this section.

Section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (d)(3)(C)(ii), is section 4003(a)(1) of Pub. L. 100–203, which amended subsec. (d)(5)(B)(ii) of this section.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(3)(C)(ii), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subsecs. (d)(3)(E)(i) and (r)(2)(B)(i)(I), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. Section 10324(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 9831(a) of the American Rescue Plan Act of 2021, referred to in subsec. (d)(3)(E)(i), is section 9831(a) of Pub. L. 117–2, which amended subsec. (d)(3)(E)(i), (iv) of this section.

Section 9304 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (e)(1)(C)(ii), is section 9304 of Pub. L. 99–509, which enacted subsecs. (d)(9) and (e)(1)(C) of this section and amended subsec. (d)(5)(C)(i)(I), (ii) of this section.

Section 4628 of the Balanced Budget Act of 1997, referred to in subsec. (h)(6)(C)(iii), is section 4628 of Pub. L. 105–33, which is set out as a note below.

Section 402 of Public Law 90–248, referred to in subsec. (h)(7)(B)(vi), (8)(A)(ii)(II), is section 402 of Pub. L. 90–248, title IV, Jan. 2, 1968, 81 Stat. 930, which enacted section 1395b–1 of this title and amended section 1395*ll* of this title.

Such section 332(a)(1)(A), referred to in subsec. (h)(8)(D)(ii)(I), probably means section 332(a)(1)(A) of the Public Health Service Act, which is classified to section 254e(a)(1)(A) of this title.

Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (i), is section 4005(e) of Pub. L. 100–203, which is set out below.

Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (m)(1), is section 1000(a)(6) [title I, §123] of Pub. L. 106–113, which enacted provisions set out as a note under this section.

Section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (m)(1), is section 1(a)(6) [title III, §307(b)] of Pub. L. 106–554, which enacted provisions set out as a note under this section.

The Health Care and Education Reconciliation Act of 2010, referred to in subsec. (r)(2)(B)(i)(I), is Pub. L. 111–152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (s)(1), is section 1000(a)(6) [title I, §124] of Pub. L. 106–113, which enacted provisions set out as a note under this section.

AMENDMENTS

2021—Subsec. (d)(3)(E)(i). Pub. L. 117–2, §9831(b), substituted '', the amendments'' for ''and the amendments'' and inserted '', and the amendments made by section 9831(a) of the American Rescue Plan Act of 2021'' after ''the Patient Protection and Affordable Care Act''.

Pub. L. 117–2, §9831(a)(1), substituted '', (iii), or (iv)'' for ''or (iii)''.

Subsec. (d)(3)(E)(iv). Pub. L. 117–2, §9831(a)(2), added cl. (iv).

2020—Subsec. (d)(4)(C)(iv). Pub. L. 116–136 added cl. (iv).

Subsec. (d)(5)(B)(v). Pub. L. 116–260, §126(b)(1), substituted ''(h)(8), and (h)(9)'' for ''and (h)(8)''.

Subsec. (d)(5)(B)(viii). Pub. L. 116–260, §131(c)(1), substituted ''paragraphs (2)(F)(iv) and (4)(H) of subsection (h)'' for ''subsection (h)(4)(H)''.

Subsec. (d)(5)(B)(x), (xi). Pub. L. 116–260, §126(b)(2), redesignated cl. (x), relating to determining the hospital's number of full-time equivalent residents, as (xi) and realigned margins.

Subsec. (d)(5)(B)(xii). Pub. L. 116–260, §126(b)(3), added cl. (xii).

Subsec. (h)(2)(F). Pub. L. 116–260, §131(a), designated existing provisions as cl. (i) and added cls. (ii) to (v).

Subsec. (h)(4)(F)(i). Pub. L. 116–260, §126(a)(1), substituted ''paragraphs (7), (8), and (9)'' for ''paragraphs (7) and (8)''.

Subsec. (h)(4)(H)(i). Pub. L. 116–260, §131(b), designated existing provisions as subcl. (I) and added subcls. (II) to (V).

Pub. L. 116–260, §126(a)(2), substituted ''paragraphs (7), (8), and (9)'' for ''paragraphs (7) and (8)''.

Subsec. (h)(4)(H)(iv). Pub. L. 116–260, §127, substituted ''Training programs in rural areas'' for ''Nonrural hospitals operating training programs in rural areas'' in heading, designated existing provisions as subcl. (I), in-

serted heading, and substituted ''For cost reporting periods beginning before October 1, 2022, in the case of'' for ''In the case of'', and added subcl. (II). Substitution in cl. (iv) heading was executed by striking ''hospitals'' instead of ''hospital'' as directed, to reflect the probable intent of Congress.

Subsec. (h)(4)(H)(iv)(I). Pub. L. 116–260, § 131(c)(2)(A), substituted ''a rural area or has'' for ''an rural area or has''.

Subsec. (h)(7)(E). Pub. L. 116–260, § 131(c)(2)(B), substituted ''under this paragraph, paragraph (8), clause (i), (ii), (iii), or (v) of paragraph (2)(F), or clause (i) or (vi) of paragraph (4)(H).'' for ''under this this paragraph, paragraph (8), paragraph (9), or paragraph (4)(H)(vi).''

Pub. L. 116–260, § 126(a)(3), (c), which amended subpar. (E) identically by inserting ''paragraph (9),'' after ''paragraph (8),'', was effectively undone by the subsequent amendment made by Pub. L. 116–260, § 131(c)(2)(B). See above.

Subsec. (h)(9). Pub. L. 116–260, § 126(a)(4), added par. (9).

2019—Subsec. (a)(4). Pub. L. 116–94, § 108(1), in introductory provisions, inserted ''for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant (as described in subsection (d)(5)(M)),'' after ''October 1, 1987),''

Subsec. (d)(4)(C)(iii). Pub. L. 116–94, § 108(2)(A), inserted ''or payments under paragraph (5)(M) (beginning with fiscal year 2021)'' after ''fiscal year 1991)'' and ''or payments under paragraph (5)(M)'' before period at end.

Subsec. (d)(5)(M). Pub. L. 116–94, § 108(2)(B), added subpar. (M).

2018—Subsec. (b)(3)(B)(viii)(XII). Pub. L. 115–271, § 6104(a), added subcl. (XII).

Subsec. (b)(3)(D). Pub. L. 115–123, § 50205(b)(1)(A), substituted ''October 1, 2022'' for ''October 1, 2017'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 115–123, § 50205(b)(1)(B), substituted ''through fiscal year 2022'' for ''through fiscal year 2017''.

Subsec. (d)(5)(G)(i). Pub. L. 115–123, § 50205(a)(1), substituted ''October 1, 2022'' for ''October 1, 2017''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 115–123, § 50205(a)(2), substituted ''October 1, 2022'' for ''October 1, 2017''.

Subsec. (d)(5)(G)(iv). Pub. L. 115–123, § 50205(a)(4), inserted concluding provisions.

Subsec. (d)(5)(G)(iv)(I). Pub. L. 115–123, § 50205(a)(3), added subcl. (I) and struck out former subcl. (I) which read as follows: ''located in a rural area,''.

Subsec. (d)(5)(J)(ii)(IV), (V). Pub. L. 115–123, § 53109(a)(1), added subcl. (IV) and redesignated former subcl. (IV) as (V).

Subsec. (d)(5)(J)(iv). Pub. L. 115–123, § 53109(a)(2)(A), inserted ''The Secretary shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV).'' after ''this subparagraph.'' in introductory provisions.

Subsec. (d)(5)(J)(iv)(I). Pub. L. 115–123, § 53109(a)(2)(B), substituted ''(III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV)'' for ''and (III)''.

Subsec. (d)(12)(B). Pub. L. 115–123, § 50204(a)(1), substituted ''fiscal year 2023'' for ''fiscal year 2018'' in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 115–123, § 50204(a)(2)(A), substituted ''through 2022, 15 road miles) from another subsection (d) hospital and has—'' for ''through 2017, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year or portion of fiscal year.'' and added subcls. (I) to (IV).

Subsec. (d)(12)(C)(ii). Pub. L. 115–123, § 50204(a)(2)(B), substituted ''subparagraphs (B) and (D)'' for ''subparagraph (B)'' and inserted ''(except as provided in clause (i)(II) and subparagraph (D)(i))'' after ''regardless''.

Subsec. (d)(12)(C)(iii). Pub. L. 115–141 added cl. (iii).

Subsec. (d)(12)(D). Pub. L. 115–123, § 50204(a)(3), substituted ''through 2022'' for ''through 2017'', ''hospitals—

''(i) with respect to each of fiscal years 2011 through 2018, with 200 or fewer''

for ''hospitals with 200 or fewer'', and ''fiscal year or portion of fiscal year; and'' for ''fiscal year.'', and added cl. (ii).

Subsec. (m)(6)(B)(i)(I). Pub. L. 115–123, § 51005(a)(1), substituted ''fiscal years 2016 through 2019'' for ''fiscal year 2016 or fiscal year 2017''.

Subsec. (m)(6)(B)(i)(II). Pub. L. 115–123, § 51005(a)(2), substituted ''2020'' for ''2018''.

Subsec. (m)(6)(B)(ii). Pub. L. 115–123, § 51005(b)(1), substituted ''Subject to clause (iv), in this paragraph'' for ''In this paragraph'' in introductory provisions.

Subsec. (m)(6)(B)(iv). Pub. L. 115–123, § 51005(b)(2), added cl. (iv).

Subsec. (n)(3)(A). Pub. L. 115–123, § 50413, struck out ''by requiring more stringent measures of meaningful use selected under this paragraph'' after ''quality over time'' in concluding provisions.

Subsec. (*o*)(2)(B)(iii). Pub. L. 115–271, § 6104(b), added cl. (iii).

2016—Subsec. (b)(3)(B)(ix)(II). Pub. L. 114–255, § 4002(b)(2), inserted after first sentence ''The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title.''

Subsec. (d)(1)(B). Pub. L. 114–255, § 15008(b), in concluding provisions, inserted ''(as in effect as of such date)'' after ''clause (iv)'' and ''(or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification)'' after ''so classified''.

Subsec. (d)(1)(B)(iv). Pub. L. 114–255, § 15008(a), struck out subcl. (I) designation before ''a hospital'' and redesignated subcl. (II) as cl. (vi).

Subsec. (d)(1)(B)(vi). Pub. L. 114–255, § 15008(a)(2), redesignated subcl. (II) of cl. (iv) as cl. (vi).

Subsec. (m)(5)(F)(i), (ii). Pub. L. 114–255, § 15008(d)(2), substituted ''(d)(1)(B)(vi)'' for ''(d)(1)(B)(iv)(II)''.

Subsec. (m)(6)(A)(i). Pub. L. 114–255, § 15010(a)(1), substituted ''(F), and (G)'' for ''and (F)''.

Pub. L. 114–255, § 15009(a)(1), substituted '', (E), and (F)'' for ''and (E)''.

Subsec. (m)(6)(E)(i)(I)(aa). Pub. L. 114–255, § 15010(a)(2), substituted ''the last sentence of subsection (d)(1)(B)'' for ''the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note, Public Law 105–33)''.

Subsec. (m)(6)(F). Pub. L. 114–255, § 15009(a)(2), added subpar. (F).

Subsec. (m)(6)(G). Pub. L. 114–255, § 15010(a)(3), added subpar. (G).

Subsec. (m)(7). Pub. L. 114–255, § 15004(b), added par. (7).

Subsec. (q)(3)(A). Pub. L. 114–255, § 15002(a)(1), inserted ''subject to subparagraph (D),'' after ''purposes of paragraph (1),''.

Subsec. (q)(3)(D), (E). Pub. L. 114–255, § 15002(a)(2), (b), added subpars. (D) and (E).

Subsec. (t). Pub. L. 114–255, § 15001, added subsec. (t).

2015—Subsec. (b)(3)(B)(ix)(I). Pub. L. 114–115, § 4(b)(1), which directed substitution of ''(n)(6)'' for ''(n)(6)(A)'', was executed by making the substitution for ''(n)(6)(B)'' to reflect the probable intent of Congress and the intervening amendment by Pub. L. 114–113, § 602(b)(1)(A). See below.

Pub. L. 114–113, § 602(b)(1)(A), substituted ''(n)(6)(B)'' for ''(n)(6)(A)''.

Subsec. (b)(3)(B)(ix)(II). Pub. L. 114–115, §4(b)(2), inserted ''(and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016)'' after ''case-by-case basis''.

Pub. L. 114–113, §602(b)(1)(B), substituted ''an eligible hospital'' for ''a subsection (d) hospital''.

Subsec. (b)(3)(D). Pub. L. 114–10, §205(b)(1)(A), substituted ''October 1, 2017'' for ''April 1, 2015'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 114–10, §205(b)(1)(B), substituted ''through fiscal year 2017'' for ''through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015''.

Subsec. (d)(5)(G)(i). Pub. L. 114–10, §205(a)(1), substituted ''October 1, 2017'' for ''April 1, 2015''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 114–10, §205(a)(2), substituted ''October 1, 2017'' for ''April 1, 2015''.

Subsec. (d)(9)(E)(iv). Pub. L. 114–113, §601(2)(A), inserted ''and before January 1, 2016,'' after ''2004,''.

Subsec. (d)(9)(E)(v). Pub. L. 114–113, §601(1), (2)(B), (3), added cl. (v).

Subsec. (d)(12)(B). Pub. L. 114–10, §204(1), substituted ''in fiscal year 2018 and subsequent fiscal years'' for ''in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years'' in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 114–10, §204(2), substituted ''fiscal years 2011 through 2017,'' for ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' in two places.

Subsec. (d)(12)(D). Pub. L. 114–10, §204(3), substituted ''fiscal years 2011 through 2017,'' for ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),''.

Subsec. (j)(3)(C)(i). Pub. L. 114–10, §411(b)(1)(A), substituted ''clauses (ii) and (iii)'' for ''clause (ii)''.

Subsec. (j)(3)(C)(ii). Pub. L. 114–10, §411(b)(1)(B), substituted ''Subject to clause (iii), after'' for ''After'' in introductory provisions.

Subsec. (j)(3)(C)(iii). Pub. L. 114–10, §411(b)(1)(C), added cl. (iii).

Subsec. (j)(7)(A)(i). Pub. L. 114–10, §411(b)(2), substituted ''subparagraphs (C)(iii) and (D) of paragraph (3)'' for ''paragraph (3)(D)''.

Subsec. (m)(3)(A). Pub. L. 114–10, §411(e)(1), substituted ''Subject to subparagraph (C), in implementing'' for ''In implementing'' in introductory provisions.

Subsec. (m)(3)(C). Pub. L. 114–10, §411(e)(2), added subpar. (C).

Subsec. (m)(6)(A)(i). Pub. L. 114–113, §231(1), substituted ''subparagraphs (C) and (E)'' for ''subparagraph (C)''.

Subsec. (m)(6)(E). Pub. L. 114–113, §231(2), added subpar. (E).

Subsec. (n)(3)(A)(ii). Pub. L. 114–10, §106(b)(2)(B), inserted before period at end '', and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology''.

Subsec. (n)(6)(B). Pub. L. 114–113, §602(a), substituted ''hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital'' for ''subsection (d) hospital''.

2014—Subsec. (b)(3)(D). Pub. L. 113–93, §106(b)(1)(A), substituted ''April 1, 2015'' for ''April 1, 2014'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 113–93, §106(b)(1)(B), substituted ''through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015'' for ''through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014''.

Subsec. (d)(5)(G)(i). Pub. L. 113–93, §106(a)(1), substituted ''April 1, 2015'' for ''April 1, 2014''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 113–93, §106(a)(2), substituted ''April 1, 2015'' for ''April 1, 2014''.

Subsec. (d)(12)(B). Pub. L. 113–93, §105(1), substituted ''in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years'' for ''in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years'' in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 113–93, §105(2), substituted ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' for ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before'' in two places.

Subsec. (d)(12)(D). Pub. L. 113–93, §105(3), substituted ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' for ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,''.

Subsec. (j)(7)(A)(i). Pub. L. 113–185, §2(c)(2)(A), substituted ''subparagraphs (C) and (F)'' for ''subparagraph (C)''.

Subsec. (j)(7)(C). Pub. L. 113–185, §2(c)(2)(B), substituted ''Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year'' for ''For fiscal year 2014 and each subsequent rate year''.

Subsec. (j)(7)(E). Pub. L. 113–185, §2(c)(2)(C), inserted ''and subparagraph (F)(i)'' after ''subparagraph (C)''.

Subsec. (j)(7)(F), (G). Pub. L. 113–185, §2(c)(2)(D), added subpars. (F) and (G).

Subsec. (m)(5)(A)(i). Pub. L. 113–185, §2(c)(3)(A), substituted ''subparagraphs (C) and (F)'' for ''subparagraph (C)''.

Subsec. (m)(5)(C). Pub. L. 113–185, §2(c)(3)(B), substituted ''Subject to subparagraph (G), for rate year'' for ''For rate year''.

Subsec. (m)(5)(E). Pub. L. 113–185, §2(c)(3)(C), inserted ''and subparagraph (F)(i)'' after ''subparagraph (C)''.

Subsec. (m)(5)(F), (G). Pub. L. 113–185, §2(c)(3)(D), added subpars. (F) and (G).

Subsec. (m)(6)(C)(iv). Pub. L. 113–93, §112(a), substituted ''Medicare fee-for-service discharges'' for ''discharges'' in subcls. (I) and (II).

2013—Subsec. (b)(3)(D). Pub. L. 113–67, §1106(b)(1)(A), substituted ''April 1, 2014'' for ''October 1, 2013'' in introductory provisions.

Pub. L. 112–240, §606(b)(1)(A), substituted ''October 1, 2013'' for ''October 1, 2012'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 113–67, §1106(b)(1)(B), inserted ''and the portion of fiscal year 2014 before April 1, 2014'' after ''through fiscal year 2013''.

Pub. L. 112–240, §606(b)(1)(B), substituted ''through fiscal year 2013'' for ''through fiscal year 2012''.

Subsec. (d)(5)(G)(i). Pub. L. 113–67, §1106(a)(1), substituted ''April 1, 2014'' for ''October 1, 2013''.

Pub. L. 112–240, §606(a)(1), substituted ''October 1, 2013'' for ''October 1, 2012''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 113–67, §1106(a)(2), substituted ''April 1, 2014'' for ''October 1, 2013''.

Pub. L. 112–240, §606(a)(2), substituted ''October 1, 2013'' for ''October 1, 2012''.

Subsec. (d)(12)(B). Pub. L. 113–67, §1105(1), substituted ''the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years'' for ''fiscal year 2014 and subsequent fiscal years'' in introductory provisions.

Pub. L. 112–240, §605(1), substituted ''2014'' for ''2013'' in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 113–67, §1105(2), inserted ''and the portion of fiscal year 2014 before'' after ''and 2013,'' in two places and ''or portion of fiscal year'' after ''during the fiscal year''.

Pub. L. 112–240, §605(2), substituted '', 2012, and 2013'' for ''and 2012'' in two places.

Subsec. (d)(12)(D). Pub. L. 113–67, §1105(3)(B), which directed insertion of ''or the portion of fiscal year'' after ''in the fiscal year'', was executed by making the insertion after ''in the fiscal year'' both places appearing to reflect the probable intent of Congress.

Pub. L. 113–67, §1105(3)(A), inserted ''and the portion of fiscal year 2014 before April 1, 2014,'' after ''and 2013,''.

Pub. L. 112–240, § 605(3), substituted '', 2012, and 2013'' for ''and 2012''.

Subsec. (m)(5)(D)(iv). Pub. L. 113–67, § 1206(c), added cl. (iv).

Subsec. (m)(6). Pub. L. 113–67, § 1206(a)(1), added par. (6).

2011—Subsec. (f)(2). Pub. L. 112–40 substituted ''quality improvement'' for ''utilization and quality control peer review'' in introductory provisions.

2010—Subsec. (a)(4). Pub. L. 111–192, § 102(a)(1), inserted ''In applying the first sentence of this paragraph, the term 'other services related to the admission' includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this subchapter that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—'' after ''hemophilia.'' and added subpars. (A) and (B).

Subsec. (b)(3)(B)(i)(XX). Pub. L. 111–148, § 3401(a)(1), substituted ''clauses (viii), (ix), (xi), and (xii)'' for ''clause (viii)''.

Subsec. (b)(3)(B)(viii)(I). Pub. L. 111–148, § 3401(a)(2), inserted ''of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))'' after ''one-quarter''.

Subsec. (b)(3)(B)(viii)(II). Pub. L. 111–148, § 3001(a)(2)(A), inserted at end ''The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (*o*).''

Subsec. (b)(3)(B)(viii)(V). Pub. L. 111–148, § 3001(a)(2)(B), substituted ''for fiscal years 2008 through 2012'' for ''beginning with fiscal year 2008''.

Subsec. (b)(3)(B)(viii)(VII). Pub. L. 111–148, § 3001(a)(2)(C), substituted ''information regarding measures submitted'' for ''data submitted''.

Subsec. (b)(3)(B)(viii)(VIII) to (XI). Pub. L. 111–148, § 3001(a)(2)(D), added subcls. (VIII) to (XI).

Subsec. (b)(3)(B)(ix)(I). Pub. L. 111–148, § 3401(a)(3), inserted ''(determined without regard to clause (viii), (xi), or (xii))'' after ''otherwise applicable under clause (i)''.

Subsec. (b)(3)(B)(x). Pub. L. 111–148, § 3001(a)(3), added cl. (x).

Subsec. (b)(3)(B)(xi), (xii). Pub. L. 111–148, § 3401(a)(4), added cls. (xi) and (xii).

Subsec. (b)(3)(B)(xii)(I). Pub. L. 111–148, § 10319(a)(1), struck out ''and'' at end.

Subsec. (b)(3)(B)(xii)(II). Pub. L. 111–152, § 1105(a)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111–148, § 10319(a)(3), after subcl. (I) and struck out ''and'' at end. See Amendment note below.

Pub. L. 111–148, § 10319(a)(3), which directed addition of subcl. (II) ''after subclause (II)'', could not be executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(xii)(III). Pub. L. 111–152, § 1105(a)(1)(B), added subcl. (III) and struck out former subcl. (III) which read ''subject to clause (xiii), for each of fiscal years 2014 through 2019, by 0.2 percentage point.''

Pub. L. 111–148, § 10319(a)(2), (4), redesignated subcl. (II) as (III) and substituted ''2014'' for ''2012''.

Subsec. (b)(3)(B)(xii)(IV), (V). Pub. L. 111–152, § 1105(a)(1)(B), added subcls. (IV) and (V).

Subsec. (b)(3)(B)(xiii). Pub. L. 111–152, § 1105(a)(2), struck out cl. (xiii) which read as follows: ''Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''

Pub. L. 111–148, § 3401(a)(4), added cl. (xiii).

Subsec. (b)(3)(D). Pub. L. 111–148, § 3124(b)(1)(A), substituted ''October 1, 2012'' for ''October 1, 2011'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 111–148, § 3124(b)(1)(B), substituted ''through fiscal year 2012'' for ''through fiscal year 2011''.

Subsec. (d)(3)(E)(i). Pub. L. 111–148, § 10324(a)(2), which directed the amendment of the third sentence of subsec. (d)(3)(E) by inserting ''and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act'' after ''2003'', was executed by making the insertion in the fifth sentence of cl. (i) to reflect the probable intent of Congress.

Pub. L. 111–148, § 10324(a)(1)(A), substituted ''clause (ii) or (iii)'' for ''clause (ii)''.

Subsec. (d)(3)(E)(iii). Pub. L. 111–148, § 10324(a)(1)(B), added cl. (iii).

Subsec. (d)(5)(B)(iv). Pub. L. 111–148, § 5504(b), designated existing provisions as subcl. (I), inserted '', and before July 1, 2010'' after ''1997'', and added subcl. (II).

Subsec. (d)(5)(B)(v). Pub. L. 111–148, § 5506(b), which directed substitution of ''subsections (h)(4)(H)(vi), (h)(7), and (h)(8)'' for ''subsections (h)(7) and (h)(8)'' in second sentence, was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Pub. L. 111–148, § 5503(b)(1), which directed the substitution, in second sentence, of ''subsections (h)(7) and (h)(8)'' for ''subsection (h)(7)'' and ''they apply'' for ''it applies'', was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Subsec. (d)(5)(B)(x). Pub. L. 111–148, § 5505(b), added cl. (x) relating to determining the hospital's number of full-time equivalent residents.

Pub. L. 111–148, § 5503(b)(2), added cl. (x) relating to indirect teaching adjustment factor for additional payment amount attributable to resident positions.

Subsec. (d)(5)(F)(i). Pub. L. 111–148, § 3133(1), substituted ''Subject to subsection (r), for'' for ''For'' in introductory provisions.

Subsec. (d)(5)(G)(i). Pub. L. 111–148, § 3124(a)(1), substituted ''October 1, 2012'' for ''October 1, 2011''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 111–148, § 3124(a)(2), substituted ''October 1, 2012'' for ''October 1, 2011''.

Subsec. (d)(7)(C). Pub. L. 111–192, § 102(a)(2), added subpar. (C).

Subsec. (d)(12)(A). Pub. L. 111–148, § 3125(1), inserted ''or (D)'' after ''subparagraph (B)''.

Subsec. (d)(12)(B). Pub. L. 111–148, § 3125(2), substituted ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'' for ''The Secretary'' in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 111–148, § 10314(1), substituted ''1,600 discharges'' for ''1,500 discharges''.

Pub. L. 111–148, § 3125(3), inserted ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles'' and ''(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''.

Subsec. (d)(12)(D). Pub. L. 111–148, § 10314(2), substituted ''1,600 discharges'' for ''1,500 discharges''.

Pub. L. 111–148, § 3125(4), added subpar. (D).

Subsec. (h)(4)(E). Pub. L. 111–148, § 5505(a)(1)(A), substituted ''Subject to subparagraphs (J) and (K), such rules'' for ''Such rules'' in introductory provisions.

Pub. L. 111–148, § 5504(a), substituted ''shall be counted and that—'' for ''shall be counted and that all the time'', inserted cl. (i) designation and ''effective for cost reporting periods beginning before July 1, 2010, all the time;'' before ''so spent'', substituted ''; and'' for period at end, added cl. (ii), and inserted concluding provisions.

Subsec. (h)(4)(F)(i). Pub. L. 111–148, §5503(a)(1), substituted ''paragraphs (7) and (8)'' for ''paragraph (7)''.

Subsec. (h)(4)(H)(i). Pub. L. 111–148, §5503(a)(2), substituted ''paragraphs (7) and (8)'' for ''paragraph (7)''.

Subsec. (h)(4)(H)(vi). Pub. L. 111–148, §5506(a), added cl. (vi).

Subsec. (h)(4)(J), (K). Pub. L. 111–148, §5505(a)(1)(B), added subpars. (J) and (K).

Subsec. (h)(5)(K). Pub. L. 111–148, §5505(a)(2), added subpar. (K).

Subsec. (h)(7)(E). Pub. L. 111–148, §5506(e), substituted ''this paragraph, paragraph (8), or paragraph (4)(H)(vi)'' for ''paragraph or paragraph (8)''.

Pub. L. 111–148, §5503(a)(3), inserted ''or paragraph (8)'' before period at end.

Subsec. (h)(8). Pub. L. 111–148, §5503(a)(4), added par. (8).

Subsec. (h)(8)(I). Pub. L. 111–309 added subpar. (I).

Subsec. (j)(3)(C). Pub. L. 111–148, §3401(d)(1), designated existing provisions as cl. (i), inserted heading and ''subject to clause (ii)'' after ''establish an increase factor'' in text, and added cl. (ii).

Subsec. (j)(3)(D). Pub. L. 111–152, §1105(c)(3), struck out cl. (i) designation and heading, redesignated subcls. (I) to (V) of former cl. (i) as cls. (i) to (v), respectively, and realigned margins.

Pub. L. 111–148, §3401(d)(2), added subpar. (D).

Subsec. (j)(3)(D)(i)(I). Pub. L. 111–148, §10319(c)(1), struck out ''and'' at end.

Subsec. (j)(3)(D)(i)(II). Pub. L. 111–152, §1105(c)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111–148, §10319(c)(3), after subcl. (I) and struck out ''and'' at end. See Amendment note below.

Pub. L. 111–148, §10319(c)(3), which directed addition of subcl. (II) ''after subclause (II)'', could not be executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (j)(3)(D)(i)(III). Pub. L. 111–152, §1105(c)(1)(B), added subcl. (III) and struck out former subcl. (III) which read as follows: ''subject to clause (ii), for each of fiscal years 2014 through 2019, 0.2 percentage point.''

Pub. L. 111–148, §10319(c)(2), (4), redesignated subcl. (II) as (III) and substituted ''2014'' for ''2012''.

Subsec. (j)(3)(D)(i)(IV), (V). Pub. L. 111–152, §1105(c)(1)(B), added subcls. (IV) and (V).

Subsec. (j)(3)(D)(ii). Pub. L. 111–152, §1105(c)(2), struck out cl. (ii). Text read as follows: ''Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''

Subsec. (j)(7), (8). Pub. L. 111–148, §3004(b), added par. (7) and redesignated former par. (7) as (8).

Subsec. (m)(3), (4). Pub. L. 111–148, §3401(c), added pars. (3) and (4).

Subsec. (m)(4)(A). Pub. L. 111–152, §1105(b)(3), struck out subpar. (A) designation and heading before ''For purposes'', redesignated cl. (i) as subpar. (A), and realigned margin.

Subsec. (m)(4)(A)(i). Pub. L. 111–148, §10319(b)(1)(A), substituted ''rate year 2010'' for ''each of rate years 2010 and 2011'' and struck out ''and'' at end.

Subsec. (m)(4)(A)(ii), (iii). Pub. L. 111–152, §1105(b)(3), redesignated cls. (ii) and (iii) as subpars. (B) and (C), respectively, and realigned margins.

Pub. L. 111–148, §10319(b)(1), (C), added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (m)(4)(A)(iv). Pub. L. 111–152, §1105(b)(3), redesignated cl. (iv) as subpar. (D) and realigned margin.

Pub. L. 111–152, §1105(b)(1), added cl. (iv) and struck out former cl. (iv), which read as follows: ''subject to subparagraph (B), for each of rate years 2014 through 2019, 0.2 percentage point.''

Pub. L. 111–148, §10319(b)(1)(B), (D), redesignated cl. (ii) as (iv) and substituted ''2014'' for ''2012''.

Subsec. (m)(4)(A)(v), (vi). Pub. L. 111–152, §1105(b)(3), redesignated cls. (v) and (vi) as subpars. (E) and (F), respectively, and realigned margins.

Pub. L. 111–152, §1105(b)(1)(B), added cls. (v) and (vi).

Subsec. (m)(4)(B). Pub. L. 111–152, §1105(b)(3), redesignated cl. (ii) of former subpar. (A) as subpar. (B) and realigned margin.

Pub. L. 111–152, §1105(b)(2), struck out subpar. (B). Prior to amendment, text read as follows: ''Subparagraph (A)(iv) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''

Pub. L. 111–148, §10319(b)(2), substituted ''(A)(iv)'' for ''(A)(ii)'' in introductory provisions.

Subsec. (m)(4)(C) to (F). Pub. L. 111–152, §1105(b)(3), redesignated cls. (iii) to (vi) of former subpar. (A) as subpars. (C) to (F), respectively, and realigned margins.

Subsec. (m)(5). Pub. L. 111–148, §3004(a), added par. (5).

Subsec. (*o*). Pub. L. 111–148, §3001(a)(1), added subsec. (*o*).

Subsec. (*o*)(2)(A). Pub. L. 111–148, §10335, inserted '', other than measures of readmissions,'' after ''shall select measures''.

Subsec. (p). Pub. L. 111–148, §3008(a), added subsec. (p).

Subsec. (q). Pub. L. 111–148, §3025(a), added subsec. (q).

Subsec. (q)(1). Pub. L. 111–148, §10309, in introductory provisions, substituted ''the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) in an amount equal to the product of'' for ''the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) for such a discharge by an amount equal to the product of''.

Subsec. (r). Pub. L. 111–148, §3133(2), added subsec. (r).

Subsec. (r)(1). Pub. L. 111–152, §1104(1), substituted ''2014'' for ''2015''.

Subsec. (r)(2). Pub. L. 111–152, §1104(2)(A), substituted ''2014'' for ''2015'' in introductory provisions.

Subsec. (r)(2)(B)(i). Pub. L. 111–152, §1104(2)(B)(i), (ii), (iv), inserted ''2014,'' after ''years'' in heading and ''2014,'' after ''each of fiscal years'' in introductory provisions and substituted ''minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017'' for ''minus 1.5 percentage points'' in concluding provisions.

Pub. L. 111–148, §10316(1)(A), (D), struck out ''(divided by 100)'' after ''change'' in introductory provisions and inserted concluding provisions.

Subsec. (r)(2)(B)(i)(I). Pub. L. 111–152, §1104(2)(B)(iii), substituted ''on the Health Care and Education Reconciliation Act of 2010'' for ''on such Act''.

Pub. L. 111–148, §10316(1)(B), substituted ''2013'' for ''2012''.

Subsec. (r)(2)(B)(i)(II). Pub. L. 111–148, §10316(1)(C), substituted comma for period at end.

Subsec. (r)(2)(B)(ii). Pub. L. 111–152, §1104(2)(C), substituted ''minus 0.2 percentage points for each of fiscal

years 2018 and 2019'' for ''and, for each of 2018 and 2019, minus 1.5 percentage points'' in concluding provisions.

Pub. L. 111–148, § 10316(2), struck out ''(divided by 100)'' after ''change'' in introductory provisions, substituted ''2013'' for ''2012'' in subcl. (I), substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (s). Pub. L. 111–148, § 3401(f), added subsec. (s).

Subsec. (s)(3). Pub. L. 111–152, § 1105(d)(3), struck out subpar. (A) designation and heading, redesignated cls. (i) to (v) of former subpar. (A) as subpars. (A) to (E), respectively, and realigned margins.

Subsec. (s)(3)(A)(i). Pub. L. 111–148, § 10319(e)(1), struck out ''and'' at end.

Subsec. (s)(3)(A)(ii). Pub. L. 111–152, § 1105(d)(1)(A), placed cl. (ii), which was directed to be added by Pub. L. 111–148, § 10319(e)(3), after cl. (i) and struck out ''and'' at end. See Amendment note below.

Pub. L. 111–148, § 10319(e)(3), which directed addition of cl. (ii) ''after clause (ii)'', could not be executed. See Amendment note above. Former cl. (ii) redesignated (iii).

Subsec. (s)(3)(A)(iii). Pub. L. 111–152, § 1105(d)(1)(B), added cl. (iii) and struck out former cl. (iii) which read as follows: ''subject to subparagraph (B), for each of the rate years beginning in 2014 through 2019, 0.2 percentage point.''

Pub. L. 111–148, § 10319(e)(2), (4), redesignated cl. (ii) as (iii) and substituted ''2014'' for ''2012''.

Subsec. (s)(3)(A)(iv), (v). Pub. L. 111–152, § 1105(d)(1)(B), added cls. (iv) and (v).

Subsec. (s)(3)(B). Pub. L. 111–152, § 1105(d)(2), struck out subpar. (B). Prior to amendment, text read as follows: ''Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''

Subsec. (s)(4). Pub. L. 111–148, § 10322(a), added par. (4).

2009—Subsec. (b)(3)(B)(viii)(I). Pub. L. 111–5, § 4102(b)(1)(A), inserted ''(or, beginning with fiscal year 2015, by one-quarter)'' after ''2.0 percentage points''.

Subsec. (b)(3)(B)(ix). Pub. L. 111–5, § 4102(b)(1)(B), added cl. (ix).

Subsec. (n). Pub. L. 111–5, § 4102(a)(1), added subsec. (n).

2008—Subsec. (b)(3)(C). Pub. L. 110–275, § 122(b)(1), substituted ''subparagraphs (I) and (L)'' for ''subparagraph (I)'' in introductory provisions.

Subsec. (b)(3)(I)(i). Pub. L. 110–275, § 122(b)(2), substituted ''Subject to subparagraph (L), for'' for ''For'' in introductory provisions.

Subsec. (b)(3)(L). Pub. L. 110–275, § 122(a), added subpar. (L).

2007—Subsec. (h)(4)(H)(v). Pub. L. 110–161, § 225(a), added cl. (v).

Subsec. (h)(7)(D), (E). Pub. L. 110–161, § 225(b)(1), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (j)(3)(C). Pub. L. 110–173, § 115(a)(1), inserted at end ''The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.''

Subsec. (m). Pub. L. 110–173, § 114(e)(1), added subsec. (m).

2006—Subsec. (b)(3)(B)(i)(XIX). Pub. L. 109–171, § 5001(a)(1)(A), substituted ''2006'' for ''2007''.

Subsec. (b)(3)(B)(i)(XX). Pub. L. 109–171, § 5001(a)(1)(B), substituted ''for each subsequent fiscal year, subject to clause (viii),'' for ''for fiscal year 2008 and each subsequent fiscal year,''.

Subsec. (b)(3)(B)(vii)(I). Pub. L. 109–171, § 5001(a)(2)(A), substituted ''for fiscal years 2005 and 2006'' for ''for each of fiscal years 2005 through 2007''.

Subsec. (b)(3)(B)(vii)(II). Pub. L. 109–171, § 5001(a)(2)(B), substituted ''For fiscal years 2005 and 2006, each'' for ''Each''.

Subsec. (b)(3)(B)(viii). Pub. L. 109–432, § 205(b)(1), realigned margins.

Pub. L. 109–171, § 5001(a)(3), added cl. (viii).

Subsec. (b)(3)(B)(viii)(III). Pub. L. 109–432, § 109(a)(2), inserted ''(including medication errors)'' after ''quality of care''.

Subsec. (b)(3)(D). Pub. L. 109–171, § 5003(b)(1), inserted ''subject to subparagraph (K),'' after ''(d)(5)(G)),'' in introductory provisions.

Pub. L. 109–171, § 5003(a)(2)(A)(i), substituted ''occurring'' for ''beginning'' and ''October 1, 2011'' for ''October 1, 2006'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 109–171, § 5003(a)(2)(A)(ii), substituted ''through fiscal year 2011'' for ''through fiscal year 2005''.

Subsec. (b)(3)(K). Pub. L. 109–171, § 5003(b)(2), added subpar. (K).

Subsec. (d)(4)(C)(iv). Pub. L. 109–432, § 106(c)(1), struck out cl. (iv) which read as follows: ''The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B) of this section.''

Subsec. (d)(4)(D). Pub. L. 109–171, § 5001(c)(1), added subpar. (D).

Subsec. (d)(5)(F)(vi). Pub. L. 109–171, § 5002(a), inserted concluding provisions.

Subsec. (d)(5)(F)(xiv)(II). Pub. L. 109–171, § 5003(d), inserted ''or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv)'' before period at end.

Subsec. (d)(5)(G)(i). Pub. L. 109–171, § 5003(a)(1)(A), substituted ''October 1, 2011'' for ''October 1, 2006''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 109–171, § 5003(c), inserted ''(or 75 percent in the case of discharges occurring on or after October 1, 2006)'' after ''50 percent''.

Pub. L. 109–171, § 5003(a)(1)(B), substituted ''October 1, 2011'' for ''October 1, 2006'' and inserted ''or for discharges in the fiscal year'' after ''for the cost reporting period''.

Subsec. (d)(7)(B). Pub. L. 109–171, § 5001(c)(2), inserted '', including the selection and revision of codes under paragraph (4)(D)'' before period at end.

Subsec. (e)(3). Pub. L. 109–432, § 106(c)(2), struck out par. (3) which read as follows: ''The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.''

2003—Subsec. (b)(3)(B)(i)(XIX), (XX). Pub. L. 108–173, § 501(a), added subcls. (XIX) and (XX) and struck out former subcl. (XIX) which read as follows: ''for fiscal year 2004 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''

Subsec. (b)(3)(B)(vii). Pub. L. 108–173, § 501(b), added cl. (vii).

Subsec. (b)(3)(I)(i)(I). Pub. L. 108–173, § 736(a)(9), substituted ''the amount'' for ''the the amount''.

Subsec. (b)(3)(I)(iii). Pub. L. 108–173, § 407(a), added cl. (iii).

Subsec. (d)(2)(C)(i). Pub. L. 108–173, § 502(b), substituted ''1999,'' for ''1999 or'' and inserted '', or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003'' before comma at end.

Subsec. (d)(2)(C)(iv). Pub. L. 108–173, § 402(b)(2), struck out ''or'' before ''the enactment of section 303'' and inserted '', or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003'' before period at end.

Subsec. (d)(3). Pub. L. 108–173, §401(b)(2)(A), inserted '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate'' in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 108–173, §401(b)(3), substituted ''in an urban area'' for ''in an other urban area''.

Subsec. (d)(3)(A)(iv). Pub. L. 108–173, §401(a), designated existing provisions as subcl. (I), substituted ''Subject to subclause (II), for discharges'' for ''For discharges'', and added subcl. (II).

Subsec. (d)(3)(D). Pub. L. 108–173, §401(b)(1)(A), (B), (2)(B), in heading, struck out ''in different areas'' after ''hospitals'' and, in introductory provisions, inserted '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate'' and struck out '', each of'' before ''which is equal—''.

Subsec. (d)(3)(D)(i). Pub. L. 108–173, §401(b)(1)(C)(i), inserted ''for fiscal years before fiscal year 2004,'' before ''for hospitals'' in introductory provisions.

Subsec. (d)(3)(D)(i)(II). Pub. L. 108–173, §401(b)(1)(C)(ii), struck out ''and'' at end.

Subsec. (d)(3)(D)(ii). Pub. L. 108–173, §401(b)(1)(D)(i), inserted ''for fiscal years before fiscal year 2004,'' before ''for hospitals'' in introductory provisions.

Subsec. (d)(3)(D)(ii)(II). Pub. L. 108–173, §401(b)(1)(D)(ii), substituted ''; and'' for period at end.

Subsec. (d)(3)(D)(iii). Pub. L. 108–173, §401(b)(1)(E), added cl. (iii).

Subsec. (d)(3)(E). Pub. L. 108–173, §403(a), designated existing provisions as cl. (i), inserted cl. heading, substituted ''Except as provided in clause (ii), the Secretary'' for ''The Secretary'', inserted at end ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.'', and added cl. (ii).

Subsec. (d)(5)(B)(ii). Pub. L. 108–173, §422(b)(1)(A), substituted ''Subject to clause (ix), for discharges'' for ''For discharges'' in introductory provisions.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 108–173, §502(a)(1), struck out ''and'' at end.

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 108–173, §502(a)(2), inserted ''and before April 1, 2004,'' after ''on or after October 1, 2002,'' and substituted semicolon for period at end.

Subsec. (d)(5)(B)(ii)(VIII) to (XII). Pub. L. 108–173, §502(a)(3), added subcls. (VIII) to (XII).

Subsec. (d)(5)(B)(v). Pub. L. 108–173, §422(b)(1)(B), inserted at end ''The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i).''

Subsec. (d)(5)(B)(ix). Pub. L. 108–173, §422(b)(1)(C), added cl. (ix).

Subsec. (d)(5)(F)(iv)(II) to (VI). Pub. L. 108–173, §402(b)(1)(A), inserted ''subject to clause (xiv) and'' before ''for discharges occurring''.

Subsec. (d)(5)(F)(viii). Pub. L. 108–173, §402(b)(1)(B), substituted ''Subject to clause (xiv), the formula'' for ''The formula''.

Subsec. (d)(5)(F)(x) to (xiii). Pub. L. 108–173, §402(b)(1)(C), substituted ''Subject to clause (xiv), for purposes'' for ''For purposes'' in introductory provisions.

Subsec. (d)(5)(F)(xiv). Pub. L. 108–173, §402(a), added cl. (xiv).

Subsec. (d)(5)(K)(i). Pub. L. 108–173, §503(b)(2)(A), inserted at end ''Such mechanism shall be modified to meet the requirements of clause (viii).''

Subsec. (d)(5)(K)(ii)(I). Pub. L. 108–173, §503(b)(1), inserted ''(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

Subsec. (d)(5)(K)(ii)(III). Pub. L. 108–173, §503(d)(1), struck out ''subject to paragraph (4)(C)(iii),'' before ''provide for additional payment''.

Subsec. (d)(5)(K)(vii). Pub. L. 108–173, §503(a), added cl. (vii).

Subsec. (d)(5)(K)(viii). Pub. L. 108–173, §503(b)(2)(B), added cl. (viii).

Subsec. (d)(5)(K)(ix). Pub. L. 108–173, §503(c), added cl. (ix).

Subsec. (d)(7)(A). Pub. L. 108–173, §406(b), inserted ''or the determination of the applicable percentage increase under paragraph (12)(A)(ii)'' after ''to subsection (e)(1)''.

Subsec. (d)(9)(A). Pub. L. 108–173, §401(c)(1)(B), added cl. (ii) and concluding provisions and struck out former cl. (ii) which read as follows: ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent) of the discharge-weighted average of—

''(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

''(II) such rate for hospitals located in other urban areas, and

''(III) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.''

Subsec. (d)(9)(A)(i). Pub. L. 108–173, §§401(c)(1)(A), 504(1)(A), substituted ''the applicable Puerto Rico percentage (specified in subparagraph (E))'' for ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and struck out ''and'' at end.

Subsec. (d)(9)(A)(ii). Pub. L. 108–173, §504(1)(B), which directed the substitution of ''the applicable Federal percentage (specified in subparagraph (E))'' for ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'', could not be executed because of the amendment by Pub. L. 108–173, §401(c)(1)(B). See above.

Subsec. (d)(9)(C)(i). Pub. L. 108–173, §401(c)(2)(A), designated existing provisions as subcl. (I), substituted ''For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary'' for ''The Secretary'', and added subcl. (II).

Subsec. (d)(9)(C)(ii). Pub. L. 108–173, §401(c)(2)(B), inserted ''(or for fiscal year 2004 and thereafter, the average standardized amount)'' after ''each of the average standardized amounts''.

Subsec. (d)(9)(C)(iii)(I). Pub. L. 108–173, §401(c)(2)(C), struck out ''for hospitals located in an urban or rural area, respectively'' after ''reduced under clause (ii))''.

Subsec. (d)(9)(C)(iv). Pub. L. 108–173, §403(b), designated existing provisions as subcl. (I), substituted ''paragraph (3)(E)(i)'' for ''paragraph (3)(E)'', and added subcl. (II).

Subsec. (d)(9)(E). Pub. L. 108–173, §504(2), added subpar. (E).

Subsec. (d)(12). Pub. L. 108–173, §406(a), added par. (12).

Subsec. (d)(13). Pub. L. 108–173, §505(a), added par. (13).

Subsec. (g)(3)(B). Pub. L. 108–173, §736(a)(15), inserted closing parenthesis after ''(as defined in subsection (d)(5)(D)(iii)''.

Subsec. (h)(2)(D)(iv)(I). Pub. L. 108–173, §711(1), in heading, inserted ''and 2004 through 2013'' after ''and 2002'' and, in text, inserted ''or during the period beginning with fiscal year 2004 and ending with fiscal year 2013'' after ''during fiscal year 2001 or fiscal year 2002''.

Subsec. (h)(2)(D)(iv)(II). Pub. L. 108–173, §711(2), substituted ''For the'' for ''For a'' and struck out ''fiscal year 2004, or fiscal year 2005,'' after ''during fiscal year 2003,''.

Subsec. (h)(3)(D)(ii)(III). Pub. L. 108–173, §736(c)(6), struck out ''and'' at end.

Subsec. (h)(4)(F)(i). Pub. L. 108–173, §422(a)(1), inserted ''subject to paragraph (7),'' after ''October 1, 1997,''.

Subsec. (h)(4)(H)(i). Pub. L. 108–173, §422(a)(2), inserted ''and subject to paragraph (7)'' after ''subparagraphs (F) and (G)''.

Subsec. (h)(7). Pub. L. 108–173, §422(a)(3), added par. (7).

2000—Subsec. (b)(3)(B)(i)(XVI). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(1)], substituted ''for hospitals in all areas,'' for ''minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,''.

Subsec. (b)(3)(B)(i)(XVII). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(2)(B)], struck out ''and'' at end.

Pub. L. 106–554, §1(a)(6) [title III, §301(a)(2)(A)], which directed amendment of subcl. (XVII) by ''striking 'minus 1.1 percentage points' and inserting 'minus 0.55 percentage points; and'', was executed as if an end quotation mark for the inserted material followed ''points'', to reflect the probable intent of Congress.

Subsec. (b)(3)(B)(i)(XVIII). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(5)], added subcl. (XVIII). Former subcl. (XVIII) redesignated (XIX).

Subsec. (b)(3)(B)(i)(XIX). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(3), (4)], redesignated subcl. (XVIII) as (XIX) and substituted ''fiscal year 2004'' for ''fiscal year 2003''.

Subsec. (b)(3)(H)(ii)(III). Pub. L. 106–554, §1(a)(6) [title III, §307(a)(1)(A)], inserted ''subject to subparagraph (J),'' after ''2002,''.

Subsec. (b)(3)(I)(i). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(1)], in introductory provisions, substituted ''there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital'' for ''that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for such target amount''.

Subsec. (b)(3)(I)(i)(I). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(2)], substituted ''the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the 'subsection (d)(5)(D)(i) amount')'' for ''target amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the 'subparagraph (C) target amount')''.

Subsec. (b)(3)(I)(i)(II), (III). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(3)], substituted ''subsection (d)(5)(D)(i) amount'' for ''subparagraph (C) target amount''.

Subsec. (b)(3)(J). Pub. L. 106–554, §1(a)(6) [title III, §307(a)(1)(B)], added subpar. (J).

Subsec. (d)(1)(B)(v)(III). Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(a)], added subcl. (III).

Subsec. (d)(1)(E). Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(b)], substituted ''For purposes of subclauses (II) and (III) of subparagraph (B)(v)'' for ''For purposes of subparagraph (B)(v)(II)''.

Subsec. (d)(2)(C)(i). Pub. L. 106–554, §1(a)(6) [title III, §302(c)], inserted ''or of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'' after ''Balanced Budget Refinement Act of 1999''.

Subsec. (d)(2)(C)(iv). Pub. L. 106–554, §1(a)(6) [title III, §303(c)], substituted ''1989,'' for ''1989 or'' and inserted '', or the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'' after ''Omnibus Budget Reconciliation Act of 1990''.

Subsec. (d)(3)(A)(vi). Pub. L. 106–554, §1(a)(6) [title III, §301(e)(1)], added cl. (vi).

Subsec. (d)(3)(E). Pub. L. 106–554, §1(a)(6) [title III, §304(c)(2)], in third sentence, substituted ''Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure'' for ''To the extent determined feasible by the Secretary, such survey shall measure''.

Subsec. (d)(4)(C)(i). Pub. L. 106–554, §1(a)(6) [title V, §533(b)(3)], substituted ''technology (including a new medical service or technology under paragraph (5)(K)),'' for ''technology,''.

Subsec. (d)(5)(B). Pub. L. 106–554, §1(a)(6) [title III, §302(d)], realigned margins.

Subsec. (d)(5)(B)(ii)(V). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(1)], struck out ''and'' at end.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(4)], added subcl. (VI). Former subcl. (VI) redesignated (VII).

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(2), (3)], redesignated subcl. (VI) as (VII) and substituted ''2002'' for ''2001''.

Subsec. (d)(5)(F)(i). Pub. L. 106–554, §1(a)(6) [title III, §303(d)(1)], struck out ''and before October 1, 1997,'' before ''the Secretary shall provide'' in introductory provisions.

Subsec. (d)(5)(F)(iv)(II). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(5)(A)], inserted ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii)'' after ''5 percent''.

Subsec. (d)(5)(F)(iv)(III). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(3)(A)], inserted ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii)'' after ''4 percent''.

Subsec. (d)(5)(F)(iv)(IV). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(4)], inserted ''or, for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi)'' after ''clause (viii)''.

Subsec. (d)(5)(F)(iv)(V). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(2)(A)], inserted ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi)'' after ''clause (viii)''.

Subsec. (d)(5)(F)(iv)(VI). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(1)(A)], inserted ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x)'' after ''10 percent''.

Subsec. (d)(5)(F)(v)(II). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(1)], inserted ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''30 percent''.

Subsec. (d)(5)(F)(v)(III). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(2)], inserted ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''40 percent''.

Subsec. (d)(5)(F)(v)(IV). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(3)], inserted ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''45 percent''.

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106–554, §1(a)(6) [title III, §303(a)(1)], struck out ''each of'' after ''during'' and inserted ''and 2 percent, respectively'' after ''3 percent''.

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106–554, §1(a)(6) [title III, §303(a)(2)], substituted ''3 percent'' for ''4 percent''.

Subsec. (d)(5)(F)(x). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(1)(B)], added cl. (x).

Subsec. (d)(5)(F)(xi). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(2)(B)], added cl. (xi).

Subsec. (d)(5)(F)(xii). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(3)(B)], added cl. (xii).

Subsec. (d)(5)(F)(xiii). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(5)(B)], added cl. (xiii).

Subsec. (d)(5)(G)(iv)(IV). Pub. L. 106–554, §1(a)(6) [title II, §212(a)], inserted '', or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report,'' after ''1987''.

Subsec. (d)(5)(K), (L). Pub. L. 106–554, §1(a)(6) [title V, §533(b)(1)], added subpars. (K) and (L).

Subsec. (d)(10)(D)(v), (vi). Pub. L. 106–554, §1(a)(6) [title III, §304(a)], added cls. (v) and (vi).

Subsec. (h)(2)(D)(iii). Pub. L. 106–554, §1(a)(6) [title V, §511], in heading substituted ''for'' for ''in fiscal year 2001 at 70 percent of'' and in text inserted '', and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent,'' after ''70 percent''.

Subsec. (j)(1)(A). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(A)], inserted ''other than a facility making an election under subparagraph (F)'' before ''in a cost reporting period'' in introductory provisions.

Subsec. (j)(1)(B). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(B)], inserted ''or, in the case of a facility

making an election under subparagraph (F), for any cost reporting period described in such subparagraph,'' after ''2002,''.

Subsec. (j)(1)(F). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(C)], added subpar. (F).

Subsec. (j)(3)(B). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(2)], inserted ''but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)'' after ''paragraphs (4) and (6)''.

Pub. L. 106–554, §1(a)(6) [title III, §305(a)], substituted ''98 percent for fiscal year 2001 and 100 percent for fiscal year 2002'' for ''98 percent''.

Subsec. (*l*)(2)(C). Pub. L. 106–554, §1(a)(6) [title V, §512(a)], substituted ''the ratio of—'' and cls. (i) and (ii) for ''the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods.''

1999—Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(A)], inserted a comma after ''paragraph (2)'' in concluding provisions.

Subsec. (b)(2)(A). Pub. L. 106–113, §1000(a)(6) [title I, §122(1)], substituted ''Except as provided in subparagraph (E), in addition to'' for ''In addition to''.

Subsec. (b)(2)(E). Pub. L. 106–113, §1000(a)(6) [title I, §122(2)], added subpar. (E).

Subsec. (b)(3)(B)(i)(XVI) to (XVIII). Pub. L. 106–113, §1000(a)(6) [title IV, §406], added subcls. (XVI) and (XVII), redesignated former subcl. (XVII) as (XVIII), and struck out former subcl. (XVI) which read as follows: ''for each of fiscal years 2001 and 2002, the market basket percentage increase minus 1.1 percentage point for hospitals in all areas, and''.

Subsec. (b)(3)(B)(ii)(VI). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(B)(i)], substituted comma for semicolon at end.

Subsec. (b)(3)(B)(ii)(VII). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(B)(ii)], substituted ''year,'' for ''year;''.

Subsec. (b)(3)(C). Pub. L. 106–113, §1000(a)(6) [title IV, §405(1)], inserted ''subject to subparagraph (I),'' before ''the term 'target amount' means'' in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 106–113, §1000(a)(6) [title IV, §404(b)(1)(A)], substituted ''and before October 1, 2006,'' for ''and before October 1, 2001,'' in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(2)], substituted ''and for discharges beginning on or after October 1, 1997, and before October 1, 2001,'' for ''and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 106–113, §1000(a)(6) [title IV, §404(b)(1)(B)], substituted ''fiscal year 2005'' for ''fiscal year 2000''.

Subsec. (b)(3)(H)(i) to (iii). Pub. L. 106–113, §1000(a)(6) [title I, §121(a)], added cl. (i), redesignated former cl. (i) as subcl. (I) of cl. (ii) and inserted '', as adjusted under clause (iii)'' after ''fiscal year 1996'', redesignated former cl. (ii) as subcl. (II) of cl. (ii) and substituted ''subclause (I)'' for ''clause (i)'' and ''such subclause'' for ''such clause'', added cl. (iii), and redesignated former cl. (iii) as subcl. (III) of cl. (ii).

Subsec. (b)(3)(I). Pub. L. 106–113, §1000(a)(6) [title IV, §405(2)], added subpar. (I).

Subsec. (b)(4)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(f)], struck out ''or unit'' after ''(and in the case of a hospital''.

Subsec. (b)(7)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title III, §321(h)], inserted ''(as estimated by the Secretary)'' after ''median''.

Subsec. (d)(2)(C)(i). Pub. L. 106–113, §1000(a)(6) [title I, §111(c)], inserted ''or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999'' after ''Balanced Budget Act of 1997''.

Subsec. (d)(5)(B)(ii)(V), (VI). Pub. L. 106–113, §1000(a)(6) [title I, §111(a)], added subcl. (V), redesignated former subcl. (V) as (VI), and substituted ''2001'' for ''2000'' in subcl. (VI).

Subsec. (d)(5)(B)(v). Pub. L. 106–113, §1000(a)(6) [title IV, §407(b)(2)], inserted ''(or, 130 percent of such number in the case of a hospital located in a rural area)'' after ''may not exceed the number''.

Pub. L. 106–113, §1000(a)(6) [title IV, §407(a)(2)], inserted at end ''Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause.''

Subsec. (d)(5)(F)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(16)], inserted a comma after ''1986'' in introductory provisions.

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(1)], substituted ''during each of fiscal years 2000 and 2001'' for ''during fiscal year 2000''.

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(2)–(4)], redesignated subcl. (V) as (IV), substituted ''reduced by 4 percent'' for ''reduced by 5 percent'', and struck out former subcl. (IV) which read as follows: ''during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;''.

Subsec. (d)(5)(F)(ix)(V), (VI). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(3)], redesignated subcl. (VI) as (V). Former subcl. (V) redesignated (IV).

Subsec. (d)(5)(G)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §404(a)(1)], substituted ''October 1, 2006,'' for ''October 1, 2001,''.

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(1)(A)], substituted ''or discharges occurring on or after October 1, 1997, and before October 1, 2001,'' for ''or beginning on or after October 1, 1997, and before October 1, 2001,''.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 106–113, §1000(a)(6) [title IV, §404(a)(2)], substituted ''October 1, 2006,'' for ''October 1, 2001,''.

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(1)(B)], substituted ''or discharges occurring on or after October 1, 1997, and before October 1, 2001,'' for ''or beginning on or after October 1, 1997, and before October 1, 2001,''.

Subsec. (d)(8)(B). Pub. L. 106–113, §1000(a)(6) [title IV, §402(a)], designated existing provisions as cl. (i), substituted ''described in clause (ii)'' for ''published in the Federal Register on January 3, 1980'', and added cl. (ii).

Subsec. (d)(8)(E). Pub. L. 106–113, §1000(a)(6) [title IV, §401(a)], added subpar. (E).

Subsec. (d)(9)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(17)], inserted a comma after ''1987'' in introductory provisions.

Subsec. (g)(1)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(e)], substituted ''October 1, 2002,'' for ''September 30, 2002,'' in last sentence.

Subsec. (h)(2)(D)(i). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(1), (b)(1)], inserted heading and substituted ''a subsequent clause'' for ''clause (ii)'' and ''the approved FTE resident amount determined'' for ''the amount determined''.

Subsec. (h)(2)(D)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §311(b)(2)], inserted heading and realigned margins.

Subsec. (h)(2)(D)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(2)], added cls. (iii) and (iv).

Subsec. (h)(2)(E), (F). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(3), (4)], added subpar. (E) and redesignated former subpar. (E) as (F).

Subsec. (h)(3)(D)(i). Pub. L. 106–113, §1000(a)(6) [title V, §541(b)(1)], inserted '', subject to clause (iii),'' after ''shall equal'' in introductory provisions.

Subsec. (h)(3)(D)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title V, §541(b)(2), (3)], added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (h)(4)(F). Pub. L. 106–113, §1000(a)(6) [title IV, §407(a)(1)], designated existing provisions as cl. (i), inserted heading, realigned margins, and added cl. (ii).

Subsec. (h)(4)(F)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §407(b)(1)], inserted ''(or, 130 percent of such number in the case of a hospital located in a rural area)'' after ''may not exceed the number''.

Subsec. (h)(4)(H)(iv). Pub. L. 106–113, §1000(a)(6) [title IV, §407(c)(1)], added cl. (iv).

Subsec. (h)(5)(F). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(1)], substituted ''Subject to subparagraph (G)(v), the initial residency period'' for ''The initial residency period'' in concluding provisions.

Subsec. (h)(5)(G)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(2)(A)], substituted ''(iv), and (v)'' for ''and (iv)''.

Subsec. (h)(5)(G)(v). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(2)(B)], added cl. (v).

Subsec. (j)(1)(D). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(1)], struck out '', day of inpatient hospital services, or other unit of payment defined by the Secretary'' before period at end.

Subsec. (j)(1)(E). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(3)], added subpar. (E).

Subsec. (j)(2)(A)(i). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(2)], amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: ''classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and''.

Subsec. (*l*). Pub. L. 106–113, § 1000(a)(6) [title V, § 541(a)], added subsec. (*l*).

1997—Subsec. (b)(1). Pub. L. 105–33, § 4421(b)(1), inserted ''and other than a rehabilitation facility described in subsection (j)(1)'' after ''subsection (d)(1)(B)'' in introductory provisions.

Pub. L. 105–33, § 4415(b)(1), inserted ''plus the amount, if any, provided under paragraph (2)'' before ''except that in no case'' in concluding provisions.

Subsec. (b)(1)(A). Pub. L. 105–33, § 4415(a), added cls. (i) and (ii) and concluding provisions and struck out former cls. (i) and (ii) and former concluding provisions which read as follows:

''(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

''(ii) 5 percent of the target amount,

whichever is less; or''.

Subsec. (b)(1)(B). Pub. L. 105–33, § 4415(c)(3), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (b)(1)(C). Pub. L. 105–33, § 4415(c)(1), (2), redesignated subpar. (B) as (C) and substituted ''greater than 110 percent of the target amount'' for ''greater than the target amount'' and ''exceed 110 percent of the target amount'' for ''exceed the target amount''.

Subsec. (b)(2). Pub. L. 105–33, § 4415(b)(2), added par. (2).

Subsec. (b)(3)(A). Pub. L. 105–33, §§ 4413(a)(1), 4416(2), in introductory provisions, substituted ''subparagraph (C) and succeeding subparagraph,'' for ''subparagraphs (C), (D), and (E),'' and inserted ''and in paragraph (7)(A)(ii),'' before ''for purposes of this subsection''.

Subsec. (b)(3)(B)(i). Pub. L. 105–33, § 4421(b)(2), inserted ''and subsection (j)'' after ''For purposes of subsection (d)'' in introductory provisions.

Subsec. (b)(3)(B)(i)(XIII) to (XVII). Pub. L. 105–33, § 4401(a), added subcls. (XIII) to (XVII) and struck out former subcl. (XIII) which read as follows: ''for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''

Subsec. (b)(3)(B)(ii)(VI) to (VIII). Pub. L. 105–33, § 4411(a)(1), added subcls. (VI) and (VII) and redesignated former subcl. (VI) as (VIII).

Subsec. (b)(3)(B)(vi). Pub. L. 105–33, § 4411(a)(2), added cl. (vi).

Subsec. (b)(3)(D). Pub. L. 105–33, § 4204(a)(2)(A), substituted ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'' for ''September 30, 1994,'' in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 105–33, § 4204(a)(2)(B)–(D), added cl. (iv).

Subsec. (b)(3)(F), (G). Pub. L. 105–33, § 4413(a)(2), (b), added subpars. (F) and (G).

Subsec. (b)(3)(H). Pub. L. 105–33, § 4414, added subpar. (H).

Subsec. (b)(4)(A)(i). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted ''The Secretary shall provide for an exception and adjustment to (and in the case of a hospital or unit described in subsection (d)(1)(B)(iii), may provide an exemption from)'' for ''The Secretary shall provide for an exemption from, or an exception and adjustment to,''.

Subsec. (b)(4)(A)(ii). Pub. L. 105–33, § 4411(b), inserted at end ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''

Subsec. (b)(7). Pub. L. 105–33, § 4416(1), added par. (7).

Subsec. (d)(1)(B). Pub. L. 105–33, § 4417(a)(1), inserted at end ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''

Subsec. (d)(1)(B)(iv). Pub. L. 105–33, § 4417(b)(1), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (d)(1)(B)(v). Pub. L. 105–33, § 4418(a)(1), designated existing provisions as subcl. (I), substituted '', or'' for semicolon at end, and added subcl. (II).

Subsec. (d)(1)(E). Pub. L. 105–33, § 4418(a)(2), added subpar. (E).

Subsec. (d)(2)(C)(i). Pub. L. 105–33, § 4621(a)(2), inserted at end ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997,''.

Subsec. (d)(5)(A)(ii). Pub. L. 105–33, § 4405(c), substituted ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)'' for ''exceed the applicable DRG prospective payment rate''.

Subsec. (d)(5)(B)(i)(I). Pub. L. 105–33, § 4405(a), inserted '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital''.

Subsec. (d)(5)(B)(ii). Pub. L. 105–33, § 4621(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, 1988, is equal to $1.89 \times (((1 + r)$ to the nth power) $- 1)$, where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405.''

Subsec. (d)(5)(B)(iv). Pub. L. 105–33, § 4621(b)(2), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: ''In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents) as part of the calculation of the full-time-equivalent number of interns and residents.''

Subsec. (d)(5)(B)(v) to (viii). Pub. L. 105–33, § 4621(b)(1), added cls. (v) to (viii).

Subsec. (d)(5)(D)(iii)(III). Pub. L. 105–33, § 4201(c)(4)(A), inserted ''as in effect on September 30, 1997'' before period at end.

Subsec. (d)(5)(D)(v). Pub. L. 105–33, § 4201(c)(4)(B), inserted ''as in effect on September 30, 1997'' after ''section 1395i–4(i)(1) of this title'' and substituted ''(as defined in section 1395i–4(d) of this title)'' for ''(as defined in section 1395i–4(g) of this title)''.

Subsec. (d)(5)(F)(i). Pub. L. 105–33, § 4403(a)(1), inserted ''and before October 1, 1997'' after ''May 1, 1986'' in introductory provisions.

Subsec. (d)(5)(F)(ii). Pub. L. 105–33, § 4403(a)(2), substituted ''Subject to clause (ix), the amount'' for ''The amount''.

Subsec. (d)(5)(F)(ii)(I). Pub. L. 105–33, § 4405(b), inserted '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital''.

Subsec. (d)(5)(F)(ix). Pub. L. 105–33, §4403(a)(3), added cl. (ix).

Subsec. (d)(5)(G)(i), (ii)(II). Pub. L. 105–33, §4204(a)(1), substituted ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,'' for ''October 1, 1994,''.

Subsec. (d)(5)(I)(ii). Pub. L. 105–33, §4407(1), inserted ''not taking in account the effect of subparagraph (J),'' after ''in a fiscal year,''.

Subsec. (d)(5)(J). Pub. L. 105–33, §4407(2), added subpar. (J).

Subsec. (d)(6). Pub. L. 105–33, §4644(a)(1), substituted ''August 1'' for ''September 1''.

Subsec. (d)(9)(A). Pub. L. 105–33, §4406(1), struck out ''in a fiscal year beginning on or after October 1, 1987,'' after ''inpatient hospital discharges'' in introductory provisions.

Subsec. (d)(9)(A)(i). Pub. L. 105–33, §4406(2), substituted ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' for ''75 percent''.

Subsec. (d)(9)(A)(ii). Pub. L. 105–33, §4406(3), substituted ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)'' for ''25 percent''.

Subsec. (d)(10)(C)(ii). Pub. L. 105–33, §4644(c)(1), substituted ''the first day of the 13-month period ending on September 30 of the preceding fiscal year.'' for ''the first day of the preceding fiscal year.''

Subsec. (d)(10)(D)(iii), (iv). Pub. L. 105–33, §4202(a), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (d)(11). Pub. L. 105–33, §4622, added par. (11).

Subsec. (e)(2). Pub. L. 105–33, §4022(b)(1)(A)(i), struck out par. (2) which related to appointment, composition, and responsibilities of the Prospective Payment Assessment Commission.

Subsec. (e)(3). Pub. L. 105–33, §4022(b)(1)(A)(ii), redesignated subpar. (B) as par. (3) and struck out subpar. (A) which read as follows: ''The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.''

Subsec. (e)(5)(A). Pub. L. 105–33, §4644(b)(1)(A), substituted ''April 1'' for ''May 1''.

Subsec. (e)(5)(B). Pub. L. 105–33, §4644(b)(1)(B), substituted ''August 1'' for ''September 1''.

Subsec. (e)(6). Pub. L. 105–33, §4022(b)(1)(A)(i), struck out par. (6) which related to appointments, membership, responsibilities, compensation, access to records and information, audits, and appropriations concerning the Prospective Payment Assessment Commission.

Subsec. (g)(1)(A). Pub. L. 105–33, §4402, inserted at end ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.''

Subsec. (g)(3)(B). Pub. L. 105–33, §4201(c)(1), substituted ''critical access'' for ''rural primary care''.

Subsec. (g)(4). Pub. L. 105–33, §4412, added par. (4).

Subsec. (h)(3)(B). Pub. L. 105–33, §4625(b), inserted concluding provisions.

Subsec. (h)(3)(D). Pub. L. 105–33, §4624, added subpar. (D).

Subsec. (h)(4)(F) to (H). Pub. L. 105–33, §4623, added subpars. (F) to (H).

Subsec. (h)(5)(G). Pub. L. 105–33, §4627(a), substituted ''Subject to clauses (ii), (iii), and (iv)'' for ''Subject to clauses (ii) and (iii)'' in cl. (i) and added cl. (iv).

Subsec. (h)(6). Pub. L. 105–33, §4626(a), added par. (6).

Subsec. (j). Pub. L. 105–33, §4421(a), added subsec. (j).

Subsec. (k). Pub. L. 105–33, §4625(a), added subsec. (k).

1994—Subsec. (a)(4). Pub. L. 103–432, §110(a), inserted ''(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)'' after ''3 days''.

Subsec. (b)(3)(B)(iv)(II). Pub. L. 103–432, §105(b), substituted ''(adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I))'' for ''(taking into account any portion of the 12-month cost reporting period beginning during fiscal year 1993 that occurred during fiscal year 1994)''.

Subsec. (b)(3)(D). Pub. L. 103–432, §105(a)(2), substituted ''September 30, 1994'' for ''March 31, 1993'' in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 103–432, §101(c), inserted at end ''For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.''

Subsec. (d)(5)(B)(ii). Pub. L. 103–432, §110(c), substituted ''October 1, 1988'' for ''May 1, 1986''.

Subsec. (d)(5)(D)(iii)(III). Pub. L. 103–432, §102(b)(1)(B)(i), substituted ''that is located in a rural area and designated'' for ''that is designated''.

Subsec. (d)(5)(D)(v). Pub. L. 103–432, §102(b)(1)(B)(ii), substituted ''in the case of a hospital located in a rural area and designated'' for ''in the case of a hospital designated''.

Subsec. (d)(5)(G)(ii)(I). Pub. L. 103–432, §105(a)(1), substituted ''the 36-month period beginning with the first day of the cost reporting period that begins'' for ''the first 3 12-month cost reporting periods that begin''.

Subsec. (d)(5)(I). Pub. L. 103–432, §109, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(8)(C)(iv). Pub. L. 103–432, §101(b)(1)(A), substituted ''paragraph (10)'' for ''paragraph (1)''.

Subsec. (d)(8)(C)(v). Pub. L. 103–432, §101(b)(1)(B), added cl. (v).

Subsec. (d)(10)(C)(i)(II). Pub. L. 103–432, §101(b)(2)(A), substituted ''the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies'' for ''the area wage index applicable''.

Subsec. (d)(10)(D)(i)(I). Pub. L. 103–432, §101(a)(1), inserted ''(to the extent the Secretary determines appropriate)'' after ''taking into account''.

Subsec. (d)(10)(D)(ii), (iii). Pub. L. 103–432, §101(b)(2)(B), added cl. (ii) and redesignated former cl. (ii) as (iii).

Subsec. (e)(6)(B). Pub. L. 103–432, §108, substituted ''health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities'' for ''hospital reimbursement, hospital financial management''.

Subsec. (h)(5)(E). Pub. L. 103–432, §153(a), inserted ''or any successor examination'' after ''Medical Sciences''.

1993—Subsec. (b)(3)(B)(i)(IX). Pub. L. 103–66, §13501(a)(1)(A), substituted ''percentage increase minus 2.5 percentage points for hospitals'' for ''percentage increase for hospitals'' and ''percentage increase minus 1.0 percentage point'' for ''percentage increase plus 1.5 percentage points''.

Subsec. (b)(3)(B)(i)(X). Pub. L. 103–66, §13501(a)(1)(B), substituted ''percentage increase minus 2.5 percentage points for hospitals'' for ''percentage increase for hospitals'' and struck out ''and'' at end.

Subsec. (b)(3)(B)(i)(XI). Pub. L. 103–66, §13501(a)(1)(C), struck out ''and each subsequent fiscal year'' after ''1996'', inserted ''minus 2.0 percentage points'' after ''percentage increase'', and substituted a comma for period at end.

Subsec. (b)(3)(B)(i)(XII), (XIII). Pub. L. 103–66, § 13501(a)(1)(D), added subcls. (XII) and (XIII).

Subsec. (b)(3)(B)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(i), struck out '', (C), (D),'' after ''subparagraphs (A)''.

Subsec. (b)(3)(B)(ii)(III) to (VI). Pub. L. 103–66, § 13502(a)(1), struck out ''and'' at end of subcl. (III), in subcl. (IV), substituted ''a subsequent fiscal year ending on or before September 30, 1993,'' for ''subsequent fiscal years'' and a comma for the period at end, and added subcls. (V) and (VI).

Subsec. (b)(3)(B)(iv). Pub. L. 103–66, § 13501(a)(2)(A), added cl. (iv).

Subsec. (b)(3)(B)(v). Pub. L. 103–66, § 13502(a)(2), added cl. (v).

Subsec. (b)(3)(C)(i)(II). Pub. L. 103–66, § 13501(a)(2)(B)(ii), struck out ''or'' at end.

Subsec. (b)(3)(C)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(iii), substituted ''period beginning before fiscal year 1994, the target'' for ''period, the target'', ''subparagraph (B)(iv)'' for ''subparagraph (B)(ii)'', and a comma for period at end.

Subsec. (b)(3)(C)(iii), (iv). Pub. L. 103–66, § 13501(a)(2)(B)(iv), added cls. (iii) and (iv).

Subsec. (b)(3)(D)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(v), substituted ''period beginning before fiscal year 1994, the target'' for ''period, the target'', ''subparagraph (B)(iv)'' for ''subparagraph (B)(ii)'', and '', and'' for period at end.

Subsec. (b)(3)(D)(iii). Pub. L. 103–66, § 13501(a)(2)(B)(vi), added cl. (iii).

Subsec. (b)(4)(A). Pub. L. 103–66, § 13502(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(1)(A)(iii). Pub. L. 103–66, § 13501(f), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: ''beginning on or after April 1, 1988, and ending on September 30, 1993,, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.''

Subsec. (d)(5)(A)(i). Pub. L. 103–66, § 13501(c)(1), substituted ''For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary'' for ''The Secretary''.

Subsec. (d)(5)(A)(ii). Pub. L. 103–66, § 13501(c)(2), substituted '', or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the applicable DRG prospective payment rate plus a fixed dollar amount determined by the Secretary.'' for period at end.

Subsec. (d)(5)(A)(iii). Pub. L. 103–66, § 13501(c)(3), substituted ''shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate'' for ''shall approximate''.

Subsec. (d)(5)(A)(v), (vi). Pub. L. 103–66, § 13501(c)(4), added cls. (v) and (vi).

Subsec. (d)(5)(B)(iv). Pub. L. 103–66, § 13506, inserted ''or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents)'' after ''the hospital''.

Subsec. (d)(5)(G)(i). Pub. L. 103–66, § 13501(e)(1)(A), which directed amendment of subsec. (d)(5)(G) in clause (i) in the matter preceding subclause (I), by striking ''ending on or before March 31, 1993,'' and all that follows and inserting ''before October 1, 1994, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).'', was executed by substituting the new language for ''ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—

> ''(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D) of this section, or
>
> ''(II) the amount determined under paragraph (1)(A)(iii),

whichever results in the greater payment to the hospital.'' to reflect the probable intent of Congress.

Subsec. (d)(5)(G)(ii) to (iv). Pub. L. 103–66, § 13501(e)(1)(B), (C), added cl. (ii) and redesignated former cls. (ii) and (iii) as (iii) and (iv), respectively.

Subsec. (d)(8)(C)(iv). Pub. L. 103–66, § 13501(b)(1), added cl. (iv).

Subsec. (g)(1)(A). Pub. L. 103–66, § 13501(a)(3), inserted at end ''For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on August 10, 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction.''

Subsec. (h)(2)(D). Pub. L. 103–66, § 13563(a)(1), designated existing provisions as cl. (i), substituted ''Except as provided in clause (ii), for each'' for ''For each'', and added cl. (ii).

Subsec. (h)(5)(F). Pub. L. 103–66, § 13563(b)(1)(A), struck out ''plus one year'' after ''board eligibility'' in introductory provisions.

Subsec. (h)(5)(F)(ii). Pub. L. 103–66, § 13563(b)(1)(B), inserted ''or a preventive medicine residency or fellowship program'' after ''fellowship program''.

Subsec. (h)(5)(H), (I). Pub. L. 103–66, § 13563(a)(2), added subpar. (H) and redesignated former subpar. (H) as (I).

Subsec. (h)(5)(J). Pub. L. 103–66, § 13563(c)(1), added subpar. (J).

1990—Subsec. (a)(4). Pub. L. 101–508, § 4003(a), struck out period at end of first sentence and inserted '', and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).''

Subsec. (b)(1)(B)(ii). Pub. L. 101–508, § 4005(a)(1), added cl. (ii) and struck out former cl. (ii) which read as follows: ''in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;''.

Subsec. (b)(3)(B)(i)(V). Pub. L. 101–508, § 4002(a)(1)(A), struck out ''and'' after semicolon at end.

Subsec. (b)(3)(B)(i)(VI). Pub. L. 101–508, § 4002(c)(1)(A), substituted ''in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area'' for ''in all areas''.

Pub. L. 101–508, § 4002(a)(1)(C), added subcl. (VI). Former subcl. (VI) redesignated (IX).

Pub. L. 101–508, § 4002(a)(1)(B)(i), substituted ''1994'' for ''1991''.

Subsec. (b)(3)(B)(i)(VII). Pub. L. 101–508, § 4002(c)(1)(B), substituted ''in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area'' for ''in all areas''.

Pub. L. 101–508, § 4002(a)(1)(C), added subcl. (VII).

Subsec. (b)(3)(B)(i)(VIII). Pub. L. 101–508, § 4002(c)(1)(C), substituted ''in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,'' for ''in all areas, and''.

Pub. L. 101–508, § 4002(a)(1)(C), added subcl. (VIII).

Subsec. (b)(3)(B)(i)(IX). Pub. L. 101–508, § 4002(c)(1)(E), added subcl. (IX). Former subcl. (IX) redesignated (XI).

Pub. L. 101–508, § 4002(c)(1)(D)(i), substituted ''1996'' for ''1994''.

Pub. L. 101–508, § 4002(a)(1)(B)(ii), redesignated subcl. (VI) as (IX).

Subsec. (b)(3)(B)(i)(X). Pub. L. 101–508, § 4002(c)(1)(E), added subcl. (X).

Subsec. (b)(3)(B)(i)(XI). Pub. L. 101–508, § 4002(c)(1)(D)(ii), redesignated subcl. (IX) as (XI).

Subsec. (b)(3)(B)(ii). Pub. L. 101–508, § 4002(c)(2)(A)(i), substituted ''(A), (C), (D), and (E),'' for ''(A) and (E),'' in introductory provisions.

Subsec. (b)(3)(C)(ii), (D)(ii). Pub. L. 101–508, § 4002(c)(2)(A)(ii), substituted ''subparagraph (B)(ii)'' for ''subparagraph (B)(i)''.

Subsec. (b)(4)(A). Pub. L. 101–508, § 4005(c)(1)(B), inserted at end ''The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.''

Subsec. (b)(4)(B), (C). Pub. L. 101–508, § 4005(c)(2), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (c)(4). Pub. L. 101–508, § 4008(f)(1), substituted ''payments under the State system as compared to aggregate payments which would have been made under the national system since'' for ''rate of increase from'' in last sentence.

Subsec. (d)(1)(A)(iii). Pub. L. 101–508, § 4002(e)(1), substituted ''beginning on or after April 1, 1988, and ending on September 30, 1993,'' for ''beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or, if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during the period beginning on April 1, 1988, and ending on October 20, 1990''.

Pub. L. 101–508, § 4002(c)(2)(B)(i), substituted ''large urban or other area'' for ''rural, large urban, or other urban area'' in text of cl. (iii)(II) as amended by Pub. L. 103–66, § 13501(f). See 1993 Amendment note above.

Pub. L. 101–403 substituted ''October 20, 1990'' for ''September 30, 1990''.

Subsec. (d)(2)(C)(iv). Pub. L. 101–508, § 4002(b)(4)(B), substituted ''1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990.'' for ''1989.''

Pub. L. 101–508, § 4002(b)(4)(A), struck out period at end and inserted '', except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989.''

Pub. L. 101–508, § 4002(b)(3)(A), struck out ''and before October 1, 1995,'' after ''October 1, 1986,''.

Subsec. (d)(3)(A)(ii). Pub. L. 101–508, § 4002(c)(2)(B)(ii)(I), substituted ''and ending on or before September 30, 1994, the Secretary'' for ''the Secretary''.

Subsec. (d)(3)(A)(iii) to (v). Pub. L. 101–508, § 4002(c)(2)(B)(ii)(II), (III), added cls. (iii) and (iv) and redesignated former cl. (iii) as (v).

Subsec. (d)(3)(B). Pub. L. 101–508, § 4002(c)(2)(B)(iii), substituted ''by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).'' for ''for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area.''

Subsec. (d)(3)(C)(ii). Pub. L. 101–508, § 4002(b)(3)(B)(B), substituted ''occurring on or after October 1, 1986,'' through the end of cl. (ii) for ''occurring—'' and subcls. (I) and (II) which read as follows:

''(I) on or after October 1, 1986, and before October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

''(II) on or after October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987.''

Subsec. (d)(3)(D)(i). Pub. L. 101–508, § 4002(c)(2)(B)(iv)(I), which directed amendment of cl. (i) by substituting ''a large urban area'' for ''an urban area (or,'' and all that follows through ''area),'' was executed by making the substitution for ''an urban area (or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)'' to reflect the probable intent of Congress.

Subsec. (d)(3)(D)(i)(I). Pub. L. 101–508, § 4002(c)(2)(B)(iv)(II), substituted ''a large urban area'' for ''an urban area''.

Subsec. (d)(3)(D)(ii). Pub. L. 101–508, § 4002(c)(2)(B)(v), substituted ''other areas'' for ''a rural area'' in introductory provisions and in subcl. (I).

Subsec. (d)(4)(D). Pub. L. 101–508, § 4002(g)(2)(A), struck out subpar. (D) which read as follows: ''The Commission (established under subsection (e)(2) of this section) shall consult with and make recommendations to the Secretary with respect to the need for adjustments under subparagraph (C), based upon its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities. The Commission shall report to the Congress with respect to its evaluation of any adjustments made by the Secretary under subparagraph (C).''

Subsec. (d)(5)(B)(ii). Pub. L. 101–508, § 4002(b)(3)(B)(A), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: ''For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

''(I) on or after May 1, 1986, and before October 1, 1995, is equal to $1.89\times((1+r)^{.405}-1)$, or

''(II) on or after October 1, 1995, is equal to $1.43\times((1+r)^{.5795}-1)$,

where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds.''

Subsec. (d)(5)(D)(iii). Pub. L. 101–508, § 4008(m)(2)(A), substituted ''For purposes of this subchapter, the term'' for ''The term'' at beginning.

Subsec. (d)(5)(F)(i). Pub. L. 101–508, § 4002(b)(3)(A), struck out ''and before October 1, 1995,'' after ''May 1, 1986,''.

Subsec. (d)(5)(F)(iii). Pub. L. 101–508, § 4002(b)(2), substituted ''35 percent'' for ''30 percent''.

Subsec. (d)(5)(F)(vii)(I). Pub. L. 101–508, § 4002(b)(1)(A), substituted ''greater than 20.2—'' and subdivs. (a) to (d) for ''greater than 20.2, $(P-20.2)(.65)+5.62$, or''.

Subsec. (d)(5)(F)(vii)(II). Pub. L. 101–508, § 4002(b)(1)(B), substituted ''hospital—'' and subdivs. (a) to (c) for ''hospital, $(P-15)(.6)+2.5$,''.

Subsec. (d)(8)(C)(i). Pub. L. 101–508, § 4002(h)(1)(A)(i), substituted ''area, or by treating hospitals located in one urban area as being located in another urban area—'' for ''area—''.

Subsec. (d)(8)(C)(i)(II). Pub. L. 101–508, § 4002(h)(1)(A)(ii), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: ''reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such

urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area).''

Subsec. (d)(8)(C)(ii) to (iv). Pub. L. 101–508, § 4002(h)(1)(A)(iii), (iv), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: ''If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area—

''(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

''(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area).''

Subsec. (d)(8)(D). Pub. L. 101–508, § 4002(c)(2)(B)(vi), struck out ''for hospitals located in an urban area'' after ''determined under paragraph (3)'' and struck out at end ''The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate of payments to rural hospitals not affected by subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) are not changed as a result of the application of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10).''

Subsec. (d)(10)(A). Pub. L. 101–508, § 4002(h)(2)(B)(i), substituted ''Geographic'' for ''Geographical''.

Subsec. (d)(10)(B)(i). Pub. L. 101–508, § 4002(h)(2)(B)(ii), substituted ''representative'' for ''representatives'' and struck out ''1 member shall be a member of the Prospective Payment Assessment Commission, and at least'' after ''At least''.

Subsec. (d)(10)(B)(ii). Pub. L. 101–508, § 4002(h)(2)(B)(iii), substituted ''initial'' for ''all''.

Subsec. (d)(10)(C)(iii)(II). Pub. L. 101–508, § 4002(h)(2)(B)(iv), substituted ''Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5'' for ''A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board'' and substituted ''after the date on which'' for ''after''.

Subsec. (e)(2). Pub. L. 101–508, § 4002(g)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (e)(2)(A). Pub. L. 101–508, § 4002(g)(2)(B), substituted ''The Commission'' for ''In addition to carrying out its functions under subsection (d)(4)(D) of this section, the Commission''.

Subsec. (e)(3)(A). Pub. L. 101–508, § 4002(g)(2)(C), substituted ''Congress'' for ''the Secretary'' and inserted before period at end '', together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States''.

Subsec. (e)(4). Pub. L. 101–508, § 4002(g)(2)(D), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (e)(5). Pub. L. 101–508, § 4002(g)(2)(E), substituted ''recommendations'' for ''recommendation'' in subpars. (A) and (B) and inserted at end ''To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.''

Subsec. (e)(6)(G). Pub. L. 101–508, § 4002(g)(2)(F), redesignated cls. (ii) and (iii) as (i) and (ii), respectively, and struck out former cl. (i) which read as follows: ''The Office shall report annually to the Congress on the functioning and progress of the Commission and on the status of the assessment of medical procedures and services by the Commission.''

Subsec. (g)(1)(A). Pub. L. 101–508, § 4001(b), inserted at end ''Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1395x(v) of this title).''

Subsec. (g)(3)(A)(v). Pub. L. 101–508, § 4001(a), substituted ''September 30, 1991'' for ''September 30, 1990''.

Subsec. (g)(3)(B). Pub. L. 101–508, § 4001(c), substituted ''subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1395x(mm)(1) of this title)'' for ''subsection (d)(5)(D)(iii))''.

1989—Subsec. (a)(4). Pub. L. 101–239, § 6011(a), struck out ''or,'' after ''equity capital,'' and substituted ''October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia'' for ''October 1, 1987)''.

Subsec. (b)(3)(A). Pub. L. 101–239, § 6004(b)(1)(A), substituted ''(C), (D), and (E)'' for ''(C) and (D)'' in introductory provisions.

Pub. L. 101–239, § 6003(f)(2)(i), substituted ''subparagraphs (C) and (D)'' for ''subparagraph (C)'' in introductory provisions.

Pub. L. 101–239, § 6003(e)(1)(B)(i), substituted ''(A) Except as provided in subparagraph (C), for purposes of this subsection'' for ''(A) For purposes of this subsection'' in introductory provisions.

Subsec. (b)(3)(B)(i)(V), (VI). Pub. L. 101–239, § 6003(a)(1), added subcl. (V), redesignated former subcl. (V) as (VI), and substituted ''fiscal year 1991'' for ''fiscal year 1990'' in subcl. (VI).

Subsec. (b)(3)(B)(ii). Pub. L. 101–239, § 6004(b)(1)(B), substituted ''For purposes of subparagraphs (A) and (E)'' for ''For purposes of subparagraph (A)'' in introductory provisions.

Subsec. (b)(3)(C). Pub. L. 101–239, § 6003(e)(1)(B)(ii), added subpar. (C).

Subsec. (b)(3)(D). Pub. L. 101–239, § 6003(f)(2)(ii), added subpar. (D).

Subsec. (b)(3)(E). Pub. L. 101–239, § 6004(b)(1)(C), added subpar. (E).

Subsec. (b)(4)(A). Pub. L. 101–239, § 6015(a), substituted ''deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and'' for ''deems appropriate,''.

Subsec. (c)(4). Pub. L. 101–239, § 6022, substituted ''the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available'' for ''the aggregate payment or payments per inpatient admission or discharge during the three cost reporting periods beginning on or after October 1, 1983, after which such test, at the option of the Secretary, shall no longer apply, and such State systems shall be treated in the same manner as under other waivers'' in second sentence.

Subsec. (d)(1)(B)(v). Pub. L. 101–239, § 6004(a)(1), added cl. (v).

Subsec. (d)(3)(E). Pub. L. 101–239, § 6003(h)(6), substituted ''October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)'' for ''October 1, 1990 (and at least every 36 months thereafter)'' and inserted

at end ''Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.''

Subsec. (d)(4)(C). Pub. L. 101–239, § 6003(b), designated existing provisions as cl. (i) and added cls. (ii) to (iv).

Subsec. (d)(5)(C). Pub. L. 101–239, § 6003(e)(1)(A)(i), (ii), (iv), (2)(B), redesignated former cl. (i)(I) as cl. (i), redesignated former cl. (i)(II) as cl. (ii) and substituted ''clause (i)'' for ''subclause (I)'' in three places, and redesignated former cls. (ii), (iii), and (iv) as subpars. (D), (I), and (H), respectively.

Subsec. (d)(5)(D). Pub. L. 101–239, § 6003(e)(1)(A)(iv), amended former subpar. (C)(ii) generally, redesignating it as subpar. (D) and substituting cls. (i) to (iv) relating to payments to sole community hospitals for cost reporting periods beginning on or after Apr. 1, 1990, for former single paragraph relating to payments to such hospitals for cost reporting periods beginning on or after Oct. 1, 1984.

Subsec. (d)(5)(D)(iii)(III). Pub. L. 101–239, § 6003(g)(2)(A), added subcl. (III).

Subsec. (d)(5)(D)(v). Pub. L. 101–239, § 6003(g)(2)(B), added cl. (v).

Subsec. (d)(5)(E). Pub. L. 101–239, § 6003(e)(1)(A)(iii), redesignated subpar. (D) as (E).

Subsec. (d)(5)(F)(iii). Pub. L. 101–239, § 6003(c)(3), substituted ''30 percent'' for ''25 percent''.

Subsec. (d)(5)(F)(iv)(I). Pub. L. 101–239, § 6003(c)(1)(A), substituted ''the applicable formula described in clause (vii)'' for ''the following formula: (P − 15)(.5)+2.5, where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi))''.

Subsec. (d)(5)(F)(iv)(III). Pub. L. 101–239, § 6003(c)(2)(A)(ii), inserted ''in subclause (IV) or (V) or'' after ''described''.

Subsec. (d)(5)(F)(iv)(IV) to (VI). Pub. L. 101–239, § 6003(c)(2)(A)(i), (iii), (iv), added subcls. (IV) to (VI).

Subsec. (d)(5)(F)(v)(II) to (IV). Pub. L. 101–239, § 6003(c)(2)(B), added subcl. (II), redesignated former subcls. (II) and (III) as (III) and (IV), respectively, and substituted ''area and is not described in subclause (II)'' for ''area'' in subcl. (IV).

Subsec. (d)(5)(F)(vii). Pub. L. 101–239, § 6003(c)(1)(B), added cl. (vii).

Subsec. (d)(5)(F)(viii). Pub. L. 101–239, § 6003(c)(2)(C), added cl. (viii).

Subsec. (d)(5)(G). Pub. L. 101–239, § 6003(f)(1), added subpar. (G).

Subsec. (d)(5)(H). Pub. L. 101–239, § 6003(e)(1)(A)(i), redesignated subpar. (C)(iv) as subpar. (H).

Subsec. (d)(5)(I). Pub. L. 101–239, § 6004(a)(2), struck out ''(including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)'' after ''deems appropriate''.

Pub. L. 101–239, § 6003(e)(1)(A)(ii), redesignated subpar. (C)(iii) as subpar. (I).

Subsec. (d)(8)(C). Pub. L. 101–239, § 6003(h)(3), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows:

''(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),, [sic] by treating hospitals located in a rural county or counties as being located in an urban area, reduces the wage index for that urban area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area). If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),, [sic] by treating the hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

''(ii) Clause (i) shall only apply to discharges occurring on or after October 1, 1989, and before October 1, 1991.''

Subsec. (d)(8)(C)(i). Pub. L. 101–239, § 6003(h)(2), substituted ''subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),'' for ''subparagraph (B)'' in two places.

Subsec. (d)(8)(C)(iv). Pub. L. 101–239, § 6003(h)(4), added cl. (iv).

Subsec. (d)(8)(D). Pub. L. 101–239, § 6003(h)(2)(B), substituted ''(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)'' for ''(B) and (C)'' in three places.

Subsec. (d)(9)(B)(ii)(IV). Pub. L. 101–239, § 6003(e)(2)(C), substituted ''subparagraph (D)(iii)'' for ''subparagraph (D)(v)''.

Subsec. (d)(9)(D)(iii). Pub. L. 101–239, § 6003(e)(2)(D)(ii), redesignated cl. (v) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (d)(9)(D)(iv). Pub. L. 101–239, § 6003(e)(2)(D)(i), (ii), redesignated former cl. (iii) as (iv), substituted ''Subparagraph (H)'' for ''Subparagraph (C)(iii)'', and struck out former cl. (iv) which read as follows: ''Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).''

Subsec. (d)(9)(D)(v). Pub. L. 101–239, § 6003(e)(2)(D)(iii), redesignated cl. (v) as (iii).

Subsec. (d)(10). Pub. L. 101–239, § 6003(h)(1), added par. (10).

Subsec. (g)(3)(A)(iv). Pub. L. 101–234, § 301(b)(3), (c)(3), amended cl. (iv) identically, substituting ''(as the case may be)'' for ''(as the case may) be''.

Subsec. (g)(3)(A)(v). Pub. L. 101–239, § 6002, added cl. (v).

Subsec. (g)(3)(B). Pub. L. 101–239, § 6003(e)(2)(E), substituted ''subsection (d)(5)(D)(iii)'' for ''subsection (d)(5)(C)(ii)''.

Subsec. (i). Pub. L. 101–239, § 6003(g)(4), added subsec. (i).

1988—Subsec. (b)(3)(B)(i)(III). Pub. L. 100–485, § 608(d)(18)(A), substituted ''for hospitals'' for ''for for hospitals'' before ''located in other urban areas''.

Pub. L. 100–360, § 411(b)(1)(A), substituted ''for hospitals located in other urban areas'' for ''other hospitals''.

Subsec. (b)(3)(B)(i)(IV). Pub. L. 100–485, § 608(d)(18)(A), substituted ''for hospitals'' for ''for for hospitals'' before ''located in other urban areas''.

Pub. L. 100–360, § 411(b)(1)(A), (B), substituted ''percentage points'' for ''percent'' in three places and ''for hospitals located in other urban areas'' for ''other hospitals''.

Subsec. (b)(3)(B)(i)(V). Pub. L. 100–360, § 411(b)(1)(C), inserted ''increase'' after ''market basket percentage''.

Subsec. (d)(1)(A)(iii). Pub. L. 100–360, § 411(b)(1)(G), substituted ''if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area'' for ''if greater''.

Subsec. (d)(2)(C)(i). Pub. L. 100–647, § 1018(r)(1), struck out Pub. L. 99–514, § 1895(b)(1), (2). Previously, Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(A). See 1986 Amendment note below.

Subsec. (d)(2)(C)(iv). Pub. L. 100–647, § 8401, substituted ''1995'' for ''1990''.

Pub. L. 100–647, § 1018(r)(1), struck out Pub. L. 99–514, § 1895(b)(1), (2). Previously, Pub. L. 99–509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100–203, § 4009(j)(6)(A), struck out Pub. L. 99–514, § 1895(b)(2)(A). See 1986 Amendment note below.

Subsec. (d)(2)(D). Pub. L. 100–360, §411(b)(1)(D), substituted ''the publications described in subsection (e)(5)'' for ''the publication described in subsection (e)(5)(B)'' in second sentence.

Pub. L. 100–360, §411(b)(1)(H)(i), struck out at end ''For purposes of payment under this subsection, a hospital is considered to be located in an urban area or large urban area, respectively, if the hospital is paid under this subsection at the rate for hospitals located in such an area.''

Subsec. (d)(3)(A). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(A)(i). Pub. L. 100–360, §411(b)(1)(E)(i), as added by Pub. L. 100–485, §608(d)(18)(B), substituted ''occurring'' for ''occuring'' in first sentence.

Pub. L. 100–360, §411(b)(1)(E)(ii), formerly §411(b)(1)(E), as redesignated by Pub. L. 100–485, §608(d)(18)(B), made technical correction to Pub. L. 100–203, §4002(c)(1)(B)(iii), see 1987 Amendment note below.

Subsec. (d)(3)(A)(ii). Pub. L. 100–360, §411(b)(1)(F), substituted ''in other urban areas'' for ''in urban areas''.

Subsec. (d)(3)(C)(ii). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(C). See 1986 Amendment note below.

Subsec. (d)(3)(C)(ii)(I), (II). Pub. L. 100–647, §8401, substituted ''1995'' for ''1990''.

Subsec. (d)(3)(C)(iii). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(B)(i), as amended by Pub. L. 100–203, §4009(j)(6)(A), struck out Pub. L. 99–514, §1895(b)(2)(B). See 1986 Amendment note below.

Subsec. (d)(5)(B)(ii)(I), (II). Pub. L. 100–647, §8401, substituted ''1995'' for ''1990''.

Subsec. (d)(5)(F)(i). Pub. L. 100–647, §8401, substituted ''1995'' for ''1990''.

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100–360, §411(b)(4)(C)(i), made technical correction to directory language of Pub. L. 100–203, §4005(a)(1)(D), see 1987 Amendment note below.

Subsec. (d)(8)(B). Pub. L. 100–360, §411(b)(4)(A)(i), substituted ''For purposes of this subsection, the Secretary'' for ''The Secretary''.

Pub. L. 100–360, §411(b)(4)(A)(ii), substituted ''the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).'' for ''—

> ''(i) the rural county would otherwise be considered part of an urban area but for the fact that the rural county does not meet the standard relating to the rate of commutation between the rural county and the central county or counties of any adjacent urban area; and
>
> ''(ii) either (I) the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area is equal to at least 15 percent of the number of residents of the rural county who are employed, or (II) the sum of the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area and the number of residents of any adjacent urban area who commute for employment to the rural county is at least equal to 20 percent of the number of residents of the rural county who are employed.''

Subsec. (d)(8)(C). Pub. L. 100–647, §8403(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100–360, §411(b)(4)(B), substituted ''standardized amounts'' for ''standardized amount''.

Subsec. (d)(8)(D). Pub. L. 100–647, §8403(a)(1), redesignated former subpar. (C) as (D) and substituted ''subparagraphs (B) and (C)'' for ''subparagraph (B)'' wherever appearing.

Subsec. (d)(9)(C)(iv). Pub. L. 100–360, §411(b)(3), added Pub. L. 100–203, §4004(a)(2), see 1987 Amendment note below.

Subsec. (e)(6)(B). Pub. L. 100–360, §411(b)(8)(B), amended Pub. L. 100–203, §4009(d)(1), see 1987 Amendment note below.

Subsec. (f)(1)(A). Pub. L. 100–360, §411(b)(6)(B), added Pub. L. 100–203, §4007(b)(1)(A), (B), see 1987 Amendment note below.

Subsec. (f)(1)(B). Pub. L. 100–360, §411(b)(6)(B), added Pub. L. 100–203, §4007(b)(1)(C), see 1987 Amendment note below.

Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100–360, §411(b)(5)(B), made technical amendment to Pub. L. 100–203, §4006(a), see 1987 Amendment note below.

Subsec. (g)(3)(A)(iv). Pub. L. 100–360, §411(b)(5)(A), inserted ''for payments attributable'' after ''15 percent''.

1987—Subsec. (a)(4). Pub. L. 100–203, §4009(j)(1), inserted a comma after ''educational activities''.

Pub. L. 100–203, §4006(b)(2)(A), substituted ''other capital-related costs (as defined by the Secretary for periods before October 1, 1987)'' for ''with respect to costs incurred in cost reporting periods beginning prior to October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select), other capital-related costs, as defined by the Secretary''.

Subsec. (b)(3)(B)(i). Pub. L. 100–203, §4002(e)(1), struck out ''subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of'' after ''For purposes of''.

Subsec. (b)(3)(B)(i)(II). Pub. L. 100–203, §4002(a), struck out ''and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and'' after ''1.15 percent,''.

Subsec. (b)(3)(B)(i)(III) to (V). Pub. L. 100–203, §4002(a), added subcls. (III) to (V) and struck out former subcl. (III) which read ''for fiscal year 1989 and subsequent fiscal years, the percentage determined by the Secretary pursuant to subsection (e)(4) of this section.''

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 100–203, §4002(e)(2), (3), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted ''For purposes of this subparagraph'' for ''For purposes of clause (i)''.

Subsec. (d)(1)(A)(iii). Pub. L. 100–203, §4002(d), inserted before period at end '', or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph''.

Subsec. (d)(2)(C)(iv). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B). See 1986 Amendment note below.

Pub. L. 100–203, §4003(c), substituted ''1990'' for ''1989''.

Subsec. (d)(2)(D). Pub. L. 100–203, §4002(f)(1)(A), inserted sentence at end providing that hospital is considered located in urban area or large urban area, respectively, if it is paid under this subsection at rate for hospitals located in such area.

Pub. L. 100–203, §4002(b), in second sentence inserted definition of ''large urban area''.

Subsec. (d)(3). Pub. L. 100–203, §4002(c)(1)(A), substituted ''large urban, other urban, or rural areas'' for ''urban or rural areas'' in second sentence.

Subsec. (d)(3)(A)(i). Pub. L. 100–203, §4002(c)(1)(B), (C), as amended by Pub. L. 100–360, §411(b)(1)(E)(ii), designated existing provisions as cl. (i), substituted ''For discharges occuring [sic] in a fiscal year beginning before October 1, 1987, the Secretary'' for ''The Secretary'' and ''the fiscal year involved'' for ''each of fiscal years 1985, 1986, 1987, and 1988'', struck out '', and adjusted for subsequent fiscal years in accordance with

the final determination of the Secretary under subsection (e)(4) of this section, and adjusted to reflect the most recent case-mix data available'', and added cls. (ii) and (iii).

Subsec. (d)(3)(C)(ii). Pub. L. 100–203, §4003(c), substituted ''1990'' for ''1989'' in subcls. (I) and (II).

Pub. L. 100–203, §4003(a)(2), inserted ''and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987'' after ''Amendments of 1985'' in subcls. (I) and (II).

Subsec. (d)(3)(C)(iii). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(D). Pub. L. 100–203, §4002(c)(1)(D)(i), substituted ''hospitals in different areas'' for ''urban and rural hospitals'' in heading.

Subsec. (d)(3)(D)(i). Pub. L. 100–203, §4002(c)(1)(D)(ii), (iii), inserted ''(or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)'' after first reference to ''urban area'', and in subcl. (I) inserted ''such'' before ''an urban area''.

Subsec. (d)(3)(E). Pub. L. 100–203, §4004(a)(1), formerly §4004(a), as redesignated by Pub. L. 100–360, §411(b)(3), inserted at end ''Not later than October 1, 1990 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. To the extent determined feasible by the Secretary, such survey shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services.''

Subsec. (d)(5)(B)(ii). Pub. L. 100–203, §4003(c), substituted ''1990'' for ''1989'' in subcls. (I) and (II).

Pub. L. 100–203, §4003(a)(1), substituted ''1.89'' for ''2'' in subcl. (I) and ''1.43'' for ''1.5'' in subcl. (II).

Subsec. (d)(5)(C)(i)(I). Pub. L. 100–203, §4005(d)(1)(A), substituted ''275'' for ''500''.

Subsec. (d)(5)(C)(i)(II). Pub. L. 100–203, §4009(j)(2), inserted ''index'' after ''case mix'' in two places.

Subsec. (d)(5)(C)(ii). Pub. L. 100–203, §4005(c)(1), substituted ''1990'' for ''1988'' in second sentence and inserted after second sentence ''A subsection (d) hospital that meets the criteria for classification as a sole community hospital and otherwise qualifies for the adjustment authorized by the preceding sentence may qualify for such an adjustment without regard to the formula by which payments are determined for the hospital under paragraph (1)(A).''

Subsec. (d)(5)(F)(i). Pub. L. 100–203, §4003(c), substituted ''1990'' for ''1989''.

Subsec. (d)(5)(F)(i)(II). Pub. L. 100–203, §4009(j)(3)(A), substituted ''such net inpatient care revenues'' for second reference to ''such revenues''.

Subsec. (d)(5)(F)(iii). Pub. L. 100–203, §4003(b)(1), substituted ''25 percent'' for ''15 percent''.

Subsec. (d)(5)(F)(iv)(I). Pub. L. 100–203, §4009(j)(3)(B), substituted ''clause (v)'' for ''subclause (III)''.

Pub. L. 100–203, §4003(b)(2), struck out ''the lesser of 15 percent, or'' after ''is equal to''.

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B)(ii). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100–203, §4005(a)(1), as amended by Pub. L. 100–360, §411(b)(4)(C)(i), designated existing provisions as subpar. (A), redesignated former subpar. (A) and cls. (i) and (ii) as cl. (i) and subcls. (I) and (II), respectively, redesignated former subpar. (B) and cls. (i) and (ii) as cl. (ii) and subcl. (I) and (II), respectively, and added subpars. (B) and (C).

Subsec. (d)(9)(A)(ii). Pub. L. 100–203, §4002(c)(2), substituted ''a large urban area,'' for ''an urban area, and'' in subcl. (I), added subcl. (II), and redesignated former subcl. (II) as (III).

Subsec. (d)(9)(B). Pub. L. 100–203, §4009(j)(4), realigned margin of introductory provisions.

Subsec. (d)(9)(C)(iv). Pub. L. 100–203, §4004(a)(2), as added by Pub. L. 100–360, §411(b)(3), inserted at end ''The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.''

Subsec. (e)(3)(B). Pub. L. 100–203, §4002(f)(1)(B), struck out ''or determine'' after ''recommend''.

Subsec. (e)(4). Pub. L. 100–203, §4002(f)(1)(C), substituted ''for each fiscal year (beginning with fiscal year 1988)'' for ''for fiscal year 1988'', struck out ''and shall determine for each subsequent fiscal year the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) of this section) for discharges in that fiscal year, and'' after ''in that fiscal year'', and amended last sentence generally. Prior to amendment, last sentence read as follows: ''The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.''

Subsec. (e)(5). Pub. L. 100–203, §4009(j)(6)(B), amended Pub. L. 99–509, §9302(a)(2)(C). See 1986 Amendment note below.

Pub. L. 100–203, §4002(f)(1)(D), struck out ''or determination'' after ''recommendation'' in subpars. (A) and (B).

Subsec. (e)(6)(B). Pub. L. 100–203, §4009(d)(1), as amended by Pub. L. 100–360, §411(b)(8)(B), substituted ''include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives'' for ''provide expertise and experience in the provision and financing of health care'', and struck out last sentence which required Director to seek nominations from wide range of groups, including specified types of national organizations.

Subsec. (e)(6)(D). Pub. L. 100–203, §4083(b)(1), inserted at end ''For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.''

Subsec. (f)(1)(A). Pub. L. 100–203, §4007(b)(1)(A), (B), as added by Pub. L. 100–360, §411(b)(6)(B), inserted subpar. (A) designation and struck out '', for a period ending not earlier than September 30, 1988,'' after ''shall maintain''.

Subsec. (f)(1)(B). Pub. L. 100–203, §4007(b)(1)(C), as added by Pub. L. 100–360, §411(b)(6)(B), added subpar. (B).

Subsec. (f)(3). Pub. L. 100–93 amended par. (3) generally. Prior to amendment, par. (3) read as follows: ''The provisions of paragraphs (2), (3), and (4) of section 1395y(d) of this title shall apply to determinations under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1395y(d)(1) of this title.''

Subsec. (g)(1). Pub. L. 100–203, §4006(b)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''If the Congress does not enact legislation, after April 20, 1983, and before October 1, 1987, respecting the payment under this subchapter for capital-related costs for inpatient hospital services, no payment may be made under this subchapter for capital-related costs of capital expenditures (as defined in section 1320a–1(g) of this title and except as provided in section 1320a–1(j) of this title) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1987, unless the State has an agreement with the Secretary under section 1320a–1(b) of this title and under the agreement the State has recommended approval of the capital expenditures.''

Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100–203, §4006(a), as amended by Pub. L. 100–360, §411(b)(5)(B), substituted

''on or after October 1, 1987, and before January 1, 1988,'' for '', and'', at end of cl. (ii), added cls. (iii) and (iv), and struck out former cl. (iii) which read as follows: ''10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.''

Subsec. (g)(3)(C). Pub. L. 100–203, § 4006(b)(2)(B), struck out subpar. (C) which read as follows: ''If the Secretary provides, under subsection (a)(4) of this section, for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

''(i) notwithstanding any other provision of this subchapter, for the continuation of payment under the reasonable cost methodology described in section 1395x(v)(1) of this title with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

''(ii) in the design of such payment system that the aggregate payment amounts under this subchapter for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this subchapter that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary.''

Subsec. (h)(4)(C). Pub. L. 100–203, § 4009(j)(5), substituted ''subparagraph (D)'' for ''subparagraph (E)''.

1986—Subsec. (a)(4). Pub. L. 99–509, § 9320(g)(1), struck out '', costs of anesthesia services provided by a certified registered nurse anesthetist,'' after ''approved educational activities''.

Pub. L. 99–509, § 9303(c), substituted ''October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select)'' for ''October 1, 1987''.

Pub. L. 99–349 substituted ''1987'' for ''1986''.

Pub. L. 99–272, § 9107(a)(2), inserted ''a return on equity capital,'' after ''anesthetist,'' and ''other'' before ''capital-related costs''.

Subsec. (b)(3)(B). Pub. L. 99–272, § 9101(b), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''For purposes of subparagraph (A) and subsection (d) of this section and except as provided in subsection (e) of this section, the 'applicable percentage increase' for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year. In determining a percentage change under subsection (e)(4) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.''

Subsec. (b)(3)(B)(i)(II). Pub. L. 99–509, § 9302(a)(1), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: ''for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (e)(4) of this section, but not to exceed the market basket percentage increase (as defined in clause (ii)), and''.

Subsec. (b)(6). Pub. L. 99–514, § 2, substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954''.

Subsec. (c)(7). Pub. L. 99–272, § 9109(a), added par. (7).

Subsec. (d)(1)(A). Pub. L. 99–272, § 9102(a), substituted ''1987'' for ''1986'' in cls. (ii) and (iii).

Subsec. (d)(1)(C). Pub. L. 99–272, § 9102(b), struck out '', or discharges occurring'' after ''periods beginning'' in introductory provision, and ''and'' after ''percent;'' in cl. (ii), added cl. (iii), redesignated former cl. (iii) as (iv), and in cl. (iv) substituted ''on or after October 1, 1986, and before October 1, 1987'' for ''on or after October 1, 1985, and before October 1, 1986''.

Subsec. (d)(1)(D). Pub. L. 99–272, § 9102(c), struck out ''cost reporting periods beginning, or'' before ''discharges occurring'' in introductory provision, in cl. (i) substituted ''1986'' for ''1985'', and in cl. (ii) substituted ''1986'' and ''1987'' for ''1985'' and ''1986'', respectively.

Subsec. (d)(2)(C)(i). Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(A), which had directed the striking out of ''(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)'' after ''medical education costs''.

Pub. L. 99–272, § 9104(b)(1), inserted ''(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)'' after ''medical education costs''.

Subsec. (d)(2)(C)(iv). Pub. L. 99–509, § 9306(c), substituted ''1989'' for ''1988''.

Pub. L. 99–509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100–203, § 4009(j)(6)(A), struck out Pub. L. 99–514, § 1895(b)(2)(A), which had directed that cl. (iv) was to be struck out.

Pub. L. 99–272, § 9105(b), added cl. (iv).

Subsec. (d)(3)(A). Pub. L. 99–509, § 9302(a)(2)(A), (c), substituted ''1986, 1987, and 1988'' for ''and 1986'' and inserted provisions relating to the computation of urban and rural averages with respect to discharges occurring on or after October 1, 1987.

Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(B), which had directed insertion of ''If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.''

Pub. L. 99–272, § 9101(c)(1), substituted ''for each of fiscal years 1985 and 1986'' for ''for fiscal year 1985''.

Subsec. (d)(3)(B). Pub. L. 99–509, § 9302(b)(1), inserted ''for hospitals located in an urban area and for hospitals located in a rural area'' after ''subparagraph (A)'', and inserted before the period ''for hospitals located in such respective area''.

Subsec. (d)(3)(C). Pub. L. 99–272, § 9104(b)(2), inserted ''for fiscal year 1985'' after ''neutrality'' in heading, designated existing provision as cl. (i), substituted ''For discharges occurring in fiscal year 1985, the Secretary'' for ''The Secretary'', and added cl. (ii).

Subsec. (d)(3)(C)(ii). Pub. L. 99–509, § 9306(c), substituted ''1989'' for ''1988'' in subcls. (I) and (II).

Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(C), which had directed a general amendment of cl. (ii) to read as follows: ''The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between—

''(I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of medical education) if the indirect teaching adjustment factor were equal to 1.159r (as 'r' is defined in paragraph (5)(B)(ii)), and

''(II) that sum using the factor specified in paragraph (5)(B)(ii)(II).''

Subsec. (d)(3)(C)(iii). Pub. L. 99–509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100–203, § 4009(j)(6)(A), struck out Pub. L. 99–514, § 1895(b)(2)(B), which had added cl. (iii) reading as follows: ''The Secretary shall further reduce each of the average standardized amounts by reducing

the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals.''

Subsec. (d)(3)(D)(i)(I), (ii)(I). Pub. L. 99–272, §9104(b)(3), inserted ''or reduced'' after ''(B), and adjusted''.

Subsec. (d)(4)(C). Pub. L. 99–509, §9302(e)(1), substituted ''in fiscal year 1988 and at least annually'' for ''in fiscal year 1986 and at least every four fiscal years''.

Subsec. (d)(5)(B). Pub. L. 99–272, §9104(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2) of this section, except that in the computation under this subparagraph the Secretary shall use an educational adjustment factor equal to twice the factor provided under such regulations. In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.''

Subsec. (d)(5)(B)(ii). Pub. L. 99–509, §9306(c), substituted ''1989'' for ''1988'' in subcls. (I) and (II).

Subsec. (d)(5)(C)(i). Pub. L. 99–509, §9302(d)(1)(A), designated existing provisions as subcl. (I) and added subcl. (II).

Pub. L. 99–272, §9106(a), inserted ''and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center'' before the period in second sentence.

Pub. L. 99–272, §9105(c), struck out '', and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter'' after ''in rural areas)''.

Subsec. (d)(5)(C)(i)(I). Pub. L. 99–509, §9304(b)(1), inserted ''(other than under paragraph (9))'' after ''established under this subsection'' in first sentence.

Subsec. (d)(5)(C)(ii). Pub. L. 99–509, §9304(b)(2), inserted ''(other than under paragraph (9))'' after ''this subsection'' in second and third sentences.

Pub. L. 99–509, §9302(e)(4), substituted ''1988'' for ''1986''.

Pub. L. 99–272, §9111(a), inserted provision authorizing the Secretary to adjust amount of payments to sole community hospitals that realize a significant increase in operating costs in a cost reporting period attributable to addition of new inpatient facilities or services.

Subsec. (d)(5)(E). Pub. L. 99–509, §9320(g)(2), struck out subpar. (E) which read as follows: ''The Secretary shall provide for an additional payment amount for any subsection (d) hospital equal to the reasonable costs incurred by such hospital for anesthesia services provided by a certified registered nurse anesthetist. Payment under this subparagraph shall be the only payment made to such hospital with respect to such services.''

Subsec. (d)(5)(F). Pub. L. 99–272, §9105(a), added subpar. (F).

Subsec. (d)(5)(F)(i). Pub. L. 99–509, §9306(c), substituted ''1989'' for ''1988''.

Subsec. (d)(5)(F)(iv)(I). Pub. L. 99–509, §9306(b)(1), inserted ''or is described in the second sentence of subclause (III)'' after ''100 or more beds''.

Subsec. (d)(5)(F)(iv)(III). Pub. L. 99–509, §9306(b)(2), inserted ''and is not described in the second sentence of clause (v)'' after ''rural area''.

Subsec. (d)(5)(F)(v). Pub. L. 99–509, §9306(a), inserted at end ''A hospital located in a rural area and with 500 or more beds also 'serves a significantly disproportionate number of low income patients' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.''

Subsec. (d)(5)(F)(vi)(I). Pub. L. 99–514, §1895(b)(2)(A), formerly §1895(b)(2)(C), as amended by Pub. L. 99–509, §9307(c)(1)(B)(ii), as amended by Pub. L. 100–203, §4009(j)(6)(A), which directed the substitution of ''supplemental'' for ''supplementary'' and ''period'' for ''fiscal year'', was repealed by Pub. L. 100–647, §1018(r)(1).

Subsec. (d)(9). Pub. L. 99–509, §9304(a), added par. (9).

Subsec. (e)(1)(C). Pub. L. 99–509, §9304(c), added subpar. (C).

Subsec. (e)(3). Pub. L. 99–509, §9302(e)(3), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 99–272, §9101(c)(2), struck out ''(instead of the applicable percentage increase described in subsection (b)(3)(B) of this section)'' after ''should be used''.

Subsec. (e)(3)(A). Pub. L. 99–509, §9321(e)(2)(A), substituted ''March'' for ''April''.

Subsec. (e)(4). Pub. L. 99–509, §9302(a)(2)(B), (e)(2), substituted ''recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year'' for ''determine for each fiscal year (beginning with fiscal year 1987) and inserted at end ''The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.''

Pub. L. 99–272, §9101(c)(3), substituted ''fiscal year 1987'' for ''fiscal year 1986''.

Subsec. (e)(5). Pub. L. 99–509, §9302(a)(2)(C), as amended by Pub. L. 100–203, §4009(j)(6)(B), inserted ''recommendation or'' before ''determination'' in subpars. (A) and (B).

Subsec. (e)(5)(A). Pub. L. 99–509, §9321(e)(2)(B), substituted ''May'' for ''June''.

Subsec. (e)(6)(A). Pub. L. 99–272, §9127(a), substituted ''17 individuals'' for ''15 individuals''.

Subsec. (g)(1). Pub. L. 99–349 substituted ''1987'' for ''1986'' in two places.

Subsec. (g)(2). Pub. L. 99–272, §9107(a)(1), designated existing provision as subpar. (A), inserted ''the applicable percentage (described in subparagraph (B)) of'', and added subpar. (B).

Subsec. (g)(2)(B). Pub. L. 99–514, §1895(b)(3), realigned margins of subpar. (B).

Subsec. (g)(3). Pub. L. 99–509, §9303(a), added par. (3).

Subsec. (g)(3)(A). Pub. L. 99–509, §9303(b), inserted ''and a subsection (d) Puerto Rico hospital'' after ''subsection (d) hospital''.

Subsec. (h). Pub. L. 99–272, §9202(a), added subsec. (h).

Subsec. (h)(2)(C). Pub. L. 99–514, §1895(b)(9)(A), substituted ''subparagraph (B)'' for ''paragraph (B)''.

Subsec. (h)(4)(D). Pub. L. 99–514, §1895(b)(9)(B), (C), redesignated subpar. (E) as (D) and in cl. (ii) inserted ''but before July 1, 1987,''.

Subsec. (h)(4)(E). Pub. L. 99–509, §9314(a), added subpar. (E).

Pub. L. 99–514, §1895(b)(9)(C), redesignated former subpar. (E) as (D).

Subsec. (h)(5)(B). Pub. L. 99–514, §1895(b)(9)(D), substituted ''The'' for ''As used in this paragraph, the''.

1984—Subsec. (a)(2)(B). Pub. L. 98–369, §2354(b)(42), substituted ''disproportionate'' for ''disportionate''.

Subsec. (a)(4). Pub. L. 98–369, §2312(b), temporarily inserted '', costs of anesthesia services provided by a certified registered nurse anesthetist'' after ''approved educational activities''. See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (b)(3)(A)(ii). Pub. L. 98–369, §2354(b)(43), inserted ''of'' after ''in the case''.

Subsec. (b)(3)(B). Pub. L. 98–369, §2310(a), substituted ''one-quarter of 1 percentage point'' for ''1 percentage point'' and inserted provision that in determining the percentage change under subsec. (e) of this section with

respect to discharges occurring in any cost reporting period or fiscal year beginning on or after Oct. 1, 1985, and before Oct. 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.

Subsec. (c)(4)(A). Pub. L. 98–369, § 2315(a), substituted ''(D), and (E)'' for ''and (D)''.

Subsec. (d)(2)(D). Pub. L. 98–369, § 2315(b), struck out ''Standard'' before ''Metropolitan'' in provision following cl. (ii).

Pub. L. 98–369, § 2311(b), inserted provision for determining the region a hospital located in a Metropolitan Statistical Area would be deemed to be located.

Subsec. (d)(3)(D)(i)(I). Pub. L. 98–369, § 2354(b)(44), substituted ''(C))'' for ''(C),''.

Subsec. (d)(5)(B). Pub. L. 98–369, § 2307(b)(1), inserted provision that in determining such adjustment the Secretary not distinguish between those interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of such hospital.

Subsec. (d)(5)(C)(i). Pub. L. 98–617 substituted ''August 17, 1984'' for ''30 days after July 18, 1984'' before ''for implementation by''.

Pub. L. 98–369, § 2311(a), inserted provisions permitting a hospital classified as a rural hospital to appeal to the Secretary for reclassification as a rural referral center on the basis of criteria established and published by the Secretary and requiring the Secretary to make a final determination with respect to such appeal within 60 days after the date the appeal was submitted.

Subsec. (d)(5)(E). Pub. L. 98–369, § 2312(a), temporarily added subpar. (E). See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (d)(8). Pub. L. 98–369, § 2311(c), added par. (8).

Subsec. (e)(2). Pub. L. 98–369, § 2313(a), inserted ''(without regard to the provisions of title 5 governing appointments in the competitive service)'' after ''appointed by the Director''.

Subsec. (e)(5). Pub. L. 98–369, § 2315(c)(1), struck out ''for public comment'' after ''have published'' in provisions preceding subpar. (A).

Subsec. (e)(5)(A). Pub. L. 98–369, § 2315(c)(2), inserted ''for public comment'' after ''that fiscal year''.

Subsec. (e)(6)(C). Pub. L. 98–369, § 2313(b)(3), inserted provision that section 10(a)(1) of the Federal Advisory Committee Act not apply to any portion of a Commission meeting if the Commission, by majority vote, determines such portion of such meeting should be closed.

Subsec. (e)(6)(C)(i). Pub. L. 98–369, § 2313(b)(1), amended cl. (i) generally, substituting provision authorizing the Commission to employ and fix the compensation of an Executive Director, subject to the approval of the Director of the Office, and such other personnel, not to exceed 25, as necessary, without regard to the provisions of title 5 governing appointment in the competitive service, for provision authorizing the Commission to employ and fix the compensation of such personnel, not to exceed 25, as may be necessary to carry out its duties.

Subsec. (e)(6)(C)(iii). Pub. L. 98–369, § 2313(b)(2), inserted ''(without regard to section 5 of title 41)'' after ''Commission''.

Subsec. (e)(6)(D). Pub. L. 98–369, § 2313(b)(4), inserted provision relating to payment of physician comparability allowance in the same manner as provided under section 5948 of title 5 and providing that for such purpose subsec. (i) of such section apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.

Subsec. (e)(6)(J). Pub. L. 98–369, § 2313(d), added subpar. (J).

1983—Subsec. (a)(1)(D). Pub. L. 98–21, § 601(a)(1), added subpar. (D).

Subsec. (a)(4). Pub. L. 98–21, § 601(a)(2), inserted provision that term ''operating costs of inpatient hospital services'' does not include costs of approved educational activities, or, with respect to costs incurred in cost reporting periods beginning prior to Oct. 1, 1986, capital-related costs, as defined by the Secretary.

Pub. L. 97–448, § 309(b)(13), substituted ''as such costs are determined'' for ''and such costs are determined''.

Subsec. (b)(1). Pub. L. 98–21, § 601(b)(1), (2), in provisions preceding subpar. (A), substituted ''Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title'' for ''Notwithstanding section 1395f(b) of this title, but subject to the provisions of sections 1395e of this title'' and inserted ''(other than a subsection (d) hospital, as defined in subsection (d)(1)(B))'' after ''of a hospital''.

Pub. L. 98–21, § 601(b)(3), inserted ''(other than on the basis of a DRG prospective payment rate determined under subsection (d))'' after ''payable under this subchapter'' in provisions following subpar. (B).

Pub. L. 97–448, § 309(b)(14), substituted ''section 1395f(b) of this title,'' for ''sections 1395f(b) of this title'' in provisions preceding subpar. (A).

Subsec. (b)(2). Pub. L. 98–21, § 601(b)(4), struck out par. (2) which provided that par. (1) would not apply to cost reporting periods of hospitals beginning on or after Oct. 1, 1985.

Subsec. (b)(3)(B). Pub. L. 98–21, § 601(b)(5)–(8), inserted ''and subsection (d) of this section and except as provided in subsection (e) of this section'' after ''subparagraph (A)'', inserted ''or fiscal year'' after ''cost reporting period'' each place it appears, inserted ''before the beginning of the period or year'' after ''estimated by the Secretary'', and substituted ''will exceed'' for ''exceeds''.

Subsec. (b)(6). Pub. L. 98–21, § 601(b)(9), added par. (6) and repealed a prior par. (6) which directed the Secretary to provide for an adjustment under this paragraph in the amount of payment otherwise provided a hospital under this subsection in the case of a hospital which, as of Aug. 15, 1982, was subject to FICA taxes and which was not subject to such taxes for part or all of a cost reporting period beginning on or after Oct. 1, 1982, that in making such adjustment for a cost reporting period the Secretary was to estimate the amount of the operating costs of inpatient hospital services that would have resulted if the hospital was subject to the FICA taxes during that period, that in making such estimate the Secretary was to reduce the amount of such FICA taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrated to the satisfaction of the Secretary were incurred in the period for pensions, health, and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under subchapter II of this chapter and this subchapter, that if a hospital's operating costs of inpatient hospital services estimated under subparagraph (B) was greater than the hospital's operating costs of inpatient hospital services determined without regard to this paragraph for a cost reporting period, then the Secretary was to reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this subchapter (taking into account any limitation under subsection (a) of this section) for the period by the amount by which (i) the amount that would have been paid the hospital if (I) the amount of the operating costs of inpatient hospital services estimated under subparagraph (B) were treated as the amount of the operating costs of inpatient hospital services and (II) subsection (a) of this section did not apply to the determination, exceeded (ii) the amount that would otherwise have been paid the hospital if subsection (a) of this section (and this paragraph) did not apply, except that, in making such determination for cost reporting periods beginning on or after Oct. 1, 1984, clause (ii) of paragraph (1)(B) was to continue to apply.

Subsec. (b)(6)(C). Pub. L. 97–448, § 309(b)(15), substituted ''under this subchapter (taking into account any limitation under subsection (a) of this section)'' for ''under this subsection'' in provisions preceding cl. (i).

Subsec. (c)(1). Pub. L. 98–21, § 601(c)(1), added subpars. (D) and (E) and provisions following subpar. (E).

Subsec. (c)(3)(A). Pub. L. 98–21, § 601(c)(2)(A), substituted ''meets the requirements of subparagraphs (A),

(D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5),'' for ''meets the requirement of paragraph (1)(A)''.

Subsec. (c)(3)(B). Pub. L. 98–21, §601(c)(2)(B), inserted ''(or, if applicable, in paragraph (5))''.

Subsec. (c)(4) to (6). Pub. L. 98–21, §601(c)(3), added pars. (4) to (6).

Subsec. (d). Pub. L. 98–21, §601(d)(2), (e), added subsec. (d) and redesignated former subsec. (d), relating to the elimination of lesser-of-cost-or-charges provisions, as subsec. (j) of section 1814 of act Aug. 14, 1935, which is classified to subsec. (j) of section 1395f of this title.

Subsecs. (e) to (g). Pub. L. 98–21, §601(e), added subsecs. (e) to (g).

1982—Subsec. (d). Pub. L. 97–248, §110, added subsec. (d).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §131(d), Dec. 27, 2020, 134 Stat. 2976, provided that: ''The amendments made by this section [amending this section] shall apply to payment under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 27, 2020].''

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title VI, §602(d), Dec. 18, 2015, 129 Stat. 3024, provided that: ''The amendments made by this section [amending this section and section 1395w–23 of this title] shall apply as if included in the enactment of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), except that, in order to take into account delays in the implementation of this section, in applying subsections (b)(3)(B)(ix), (n)(2)(E)(ii), and (n)(2)(G)(i) of section 1886 of the Social Security Act [42 U.S.C. 1395ww], as amended by this section, any reference in such subsections to a particular year shall be treated with respect to a subsection (d) Puerto Rico hospital as a reference to the year that is 5 years after such particular year (or 7 years after such particular year in the case of applying subsection (b)(3)(B)(ix) of such section).''

Amendment by section 106(b)(2)(B) of Pub. L. 114–10 applicable to meaningful EHR users as of the date that is one year after Apr. 16, 2015, see section 106(b)(2)(C) of Pub. L. 114–10, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–93, title I, §112(d), Apr. 1, 2014, 128 Stat. 1045, provided that: ''The amendments made by this section [amending this section and provisions set out as notes under this section] are effective as of the date of the enactment of this Act [Apr. 1, 2014].''

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–309, title II, §203, Dec. 15, 2010, 124 Stat. 3289, provided that the amendment made by section 203 is effective as if included in the enactment of section 5503(a) of Pub. L. 111–148.

Pub. L. 111–192, title I, §102(b), June 25, 2010, 124 Stat. 1281, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [June 25, 2010].''

Pub. L. 111–148, title III, §3401(p), Mar. 23, 2010, 124 Stat. 488, provided that: ''Notwithstanding the preceding provisions of this section [amending this section and sections 1395f, 1395*l*, 1395m, 1395u, 1395rr, 1395yy, and 1395fff of this title], the amendments made by subsections (a), (c), and (d) [amending this section] shall not apply to discharges occurring before April 1, 2010.''

Pub. L. 111–148, title V, §5505(c), Mar. 23, 2010, 124 Stat. 661, provided that:

''(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section [amending this section] in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

''(2) GME.—Section 1886(h)(4)(J) of the Social Security Act [42 U.S.C. 1395ww(h)(4)(J)], as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

''(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(B)(x)(III)], as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.''

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–173, title I, §114(e)(2), Dec. 29, 2007, 121 Stat. 2505, provided that: ''Subsection (m)(2) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(m)(2)], as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.''

Pub. L. 110–173, title I, §115(a)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: ''The amendment made by paragraph (1) [amending this section] shall not apply to payment units occurring before April 1, 2008.''

Pub. L. 110–161, div. G, title II, §225(b)(2), Dec. 26, 2007, 121 Stat. 2189, provided that: ''Subject to paragraph (3) [section 225(b) of title II of div. G of Pub. L. 110–161 does not contain a par. (3)], the amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173).''

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 109(a)(2) of Pub. L. 109–432 applicable to payment for services furnished on or after Jan. 1, 2009, see section 109(c) of Pub. L. 109–432, set out as a note under section 1395*l* of this title.

Amendment by section 205(b)(1) of Pub. L. 109–432 effective as if included in the enactment of Pub. L. 109–171, see section 205(c) of Pub. L. 109–432, set out as a note under section 1395u of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §407(b), Dec. 8, 2003, 117 Stat. 2270, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 2004.''

Pub. L. 108–173, title V, §502(c), Dec. 8, 2003, 117 Stat. 2291, provided that: ''The amendments made by this section [amending this section] shall apply to discharges occurring on or after April 1, 2004.''

Pub. L. 108–173, title V, §503(e), Dec. 8, 2003, 117 Stat. 2292, provided that:

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall implement the amendments made by this section [amending this section] so that they apply to classification for fiscal years beginning with fiscal year 2005.

''(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2004 THAT ARE DENIED.—In the case of an application for a classification of a medical service or tech-

nology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

''(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

''(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.''

Pub. L. 108–173, title V, § 505(c), Dec. 8, 2003, 117 Stat. 2294, provided that: ''The amendments made by this section [amending this section and section 1395cc of this title] shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary [of Health and Human Services] may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title II, § 212(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–485, provided that: ''The amendment made by this section [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 2001.''

Pub. L. 106–554, § 1(a)(6) [title II, § 213(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 405 of BBRA [Pub. L. 106–113, § 1000(a)(6) [title IV, § 405]] (113 Stat. 1501A–372).''

Pub. L. 106–554, § 1(a)(6) [title III, § 301(e)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–492, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 2001.''

Pub. L. 106–554, § 1(a)(6) [title III, § 303(d)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–494, provided that: ''The amendment made by paragraph (1) [amending this section] is effective as if included in the enactment of BBA [Pub. L. 105–33].''

Pub. L. 106–554, § 1(a)(6) [title III, § 305(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: ''The amendments made by this section [amending this section] take effect as if included in the enactment of BBA [Pub. L. 105–33].''

Pub. L. 106–554, § 1(a)(6) [title V, § 512(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–534, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to portions of cost reporting periods occurring on or after January 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 121(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–330, provided that: ''The amendments made by subsection (a) [amending this section] apply to cost reporting periods beginning on or after October 1, 1999.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 125(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that: ''The amendments made by subsection (a) [amending this section] are effective as if included in the enactment of section 4421(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].''

Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 312(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, provided that: ''The amendments made by subsection (a) [amending this section] apply on and after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act [Nov. 29, 1999].''

Amendment by section 1000(a)(6) [title III, § 321(b), (e), (f), (h), (k)(15)–(17)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title IV, § 401(a)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, § 401(c)] of Pub. L. 106–113, set out as a note under section 1395i–4 of this title.

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 402(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–370, provided that: ''The amendments made by subsection (a) [amending this section] apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 407(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–373, provided that:

''(A) DGME.—The amendments made by paragraph (1) [amending this section] apply to cost reporting periods that begin on or after the date of the enactment of this Act [Nov. 29, 1999].

''(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring in cost reporting periods that begin on or after such date of enactment.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 407(b)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that:

''(A) DGME.—The amendment made by paragraph (1) [amending this section] applies to cost reporting periods beginning on or after April 1, 2000.

''(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring on or after April 1, 2000.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title IV, § 407(c)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that: ''The amendment made by paragraph (1) [amending this section] applies with respect to—

''(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after April 1, 2000; and

''(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after April 1, 2000.''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33, set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4201(c)(1), (4) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, § 4204(b), Aug. 5, 1997, 111 Stat. 376, provided that: ''The amendments made by subsection (a) [amending this section and provisions set out as a note below] shall apply with respect to discharges occurring on or after October 1, 1997.''

Pub. L. 105–33, title IV, § 4405(d), Aug. 5, 1997, 111 Stat. 400, provided that: ''The amendments made by this section [amending this section] apply to discharges occurring after September 30, 1997.''

Pub. L. 105–33, title IV, § 4415(e), Aug. 5, 1997, 111 Stat. 407, provided that: ''The amendments made by subsections (a) and (c) [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1997.''

Pub. L. 105–33, title IV, § 4417(a)(2), Aug. 5, 1997, 111 Stat. 408, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1995.''

Pub. L. 105–33, title IV, § 4417(b)(2), Aug. 5, 1997, 111 Stat. 408, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title IV, § 4419(a)(2), Aug. 5, 1997, 111 Stat. 409, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to hospitals or units that first qualify as a hospital or

unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) for cost reporting periods beginning on or after October 1, 1997.''

Pub. L. 105–33, title IV, §4421(c), Aug. 5, 1997, 111 Stat. 413, provided that: ''The amendments made by this section [amending this section] shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(j)(2)(D)] (as added by subsection (a)) on and after the date of the enactment of this section [Aug. 5, 1997].''

Pub. L. 105–33, title IV, §4627(b), Aug. 5, 1997, 111 Stat. 483, provided that: ''The amendments made by subsection (a) [amending this section] apply to combined medical residency training programs in effect for residency years beginning on or after July 1, 1997.''

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §101(a)(2), Oct. 31, 1994, 108 Stat. 4400, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of OBRA–1989 [Pub. L. 101–239].''

Pub. L. 103–432, title I, §153(b), Oct. 31, 1994, 108 Stat. 4437, provided that: ''The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13501(b)(3), Aug. 10, 1993, 107 Stat. 574, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1991.''

Pub. L. 103–66, title XIII, §13563(b)(2), Aug. 10, 1993, 107 Stat. 605, provided that: ''The amendments made by paragraphs (1)(A) and (1)(B) [amending this section] shall take effect on July 1, 1995, and the date of the enactment of this Act [Aug. 10, 1993], respectively.''

Pub. L. 103–66, title XIII, §13563(c)(2), Aug. 10, 1993, 107 Stat. 606, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to payments under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] for cost reporting periods beginning on or after October 1, 1992.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4002(a)(2), Nov. 5, 1990, 104 Stat. 1388–32, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4002(b)(5), Nov. 5, 1990, 104 Stat. 1388–33, provided that: ''The amendments made by paragraphs (1), (3), and (4)(B) [amending this section] shall apply to discharges occurring on or after January 1, 1991, the amendment made by paragraph (2) [amending this section] shall apply to discharges occurring on or after October 1, 1991, and the amendment made by paragraph (4)(A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

Pub. L. 101–508, title IV, §4002(c)(3), Nov. 5, 1990, 104 Stat. 1388–35, provided that: ''The amendments made by paragraph (1) and paragraph (2)(A) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991, and the amendments made by paragraph (2)(B) [amending this section] shall take effect October 1, 1994.''

Pub. L. 101–508, title IV, §4002(e)(4)[(3)], Nov. 5, 1990, 104 Stat. 1388–36, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1990.''

Pub. L. 101–508, title IV, §4002(g)(5), Nov. 5, 1990, 104 Stat. 1388–37, provided that: ''The amendments made by this subsection [amending this section and section 1395w–1 of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–508, title IV, §4002(h)(1)(B), Nov. 5, 1990, 104 Stat. 1388–38, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after January 1, 1991.''

Pub. L. 101–508, title IV, §4003(b), Nov. 5, 1990, 104 Stat. 1388–39, provided that: ''The amendment made by subsection (a) [amending this section] shall apply—

''(1) in the case of any services provided during the day immediately preceding the date of a patient's admission (without regard to whether the services are related to the admission), to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990] and before October 1, 1991;

''(2) in the case of diagnostic services (including clinical diagnostic laboratory tests), to services furnished on or after January 1, 1991; and

''(3) in the case of any other services, to services furnished on or after October 1, 1991.''

Pub. L. 101–508, title IV, §4005(a)(2), Nov. 5, 1990, 104 Stat. 1388–40, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1991.''

Pub. L. 101–508, title IV, §4005(c)(4), Nov. 5, 1990, 104 Stat. 1388–42, provided that: ''The amendments made by paragraph (1) [amending this section and section 1395h of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], and the amendments made by paragraph (2) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

Pub. L. 101–508, title IV, §4008(f)(2), Nov. 5, 1990, 104 Stat. 1388–45, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6003(a)(2), Dec. 19, 1989, 103 Stat. 2140, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1990.''

Pub. L. 101–239, title VI, §6003(c)(4), Dec. 19, 1989, 103 Stat. 2142, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to discharges occurring on or after April 1, 1990.''

Pub. L. 101–239, title VI, §6003(h)(7), Dec. 19, 1989, 103 Stat. 2158, provided that: ''The amendments made by paragraphs (3) and (4) [amending this section] shall apply to discharges occurring on or after April 1, 1990.''

Pub. L. 101–239, title VI, §6004(a)(3), Dec. 19, 1989, 103 Stat. 2159, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that—

''(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(I) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(I)] (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act [Dec. 19, 1989], such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification,

''(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act [42 U.S.C. 1395ww(g)], and

''(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act [42 U.S.C. 1395g(e)(2)].''

Pub. L. 101–239, title VI, § 6004(b)(2), Dec. 19, 1989, 103 Stat. 2160, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 1989.''

Pub. L. 101–239, title VI, § 6011(d), Dec. 19, 1989, 103 Stat. 2161, as amended by Pub. L. 103–66, title XIII, § 13505, Aug. 10, 1993, 107 Stat. 579; Pub. L. 105–33, title IV, § 4452, Aug. 5, 1997, 111 Stat. 425, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to items furnished 6 months after the date of enactment of this Act [Dec. 19, 1989] and on or before September 30, 1994, and on or after October 1, 1997.''

[Pub. L. 103–66, title XIII, § 13505, Aug. 10, 1993, 107 Stat. 579, provided in part that the amendment made by that section to section 6011(d) of Pub. L. 101–239, set out above, is effective as if included in the enactment of Pub. L. 101–239.]

Pub. L. 101–239, title VI, § 6015(c), Dec. 19, 1989, 103 Stat. 2164, provided that: ''The amendment made by subsection (a) [amending this section] shall become effective with respect to cost reporting periods beginning on or after April 1, 1990.''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 1018(r)(1) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4002(g), Dec. 22, 1987, 101 Stat. 1330–45, as amended by Pub. L. 100–360, title IV, § 411(b)(1)(I), July 1, 1988, 102 Stat. 769, provided that:

''(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (6))—

''(A) the amendments made by subsections (a) and (c) [amending this section] shall apply to payments made under section 1886(d)(1)(A)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)(iii)] on the basis of discharges occurring on or after April 1, 1988, and

''(B) for discharges occurring on or after October 1, 1988, the applicable percentage increase (described in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1987 is deemed to have been such percentage increase as amended by subsection (a).

''(2) PPS SOLE COMMUNITY HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital which receives payments made under section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)] because it is a sole community hospital—

''(A) the amendment made by subsections (a) and (c) [amending this section] shall apply to payments under section 1886(d)(1)(A)(ii)(I) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting period beginning on or after October 1, 1987;

''(B) notwithstanding subparagraph (A), for cost reporting period beginning during fiscal year 1988, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for the—

''(i) first 51 days of the cost reporting period shall be 0 percent,

''(ii) next 132 days of such period shall be 2.7 percent, and

''(iii) remainder of such period of the cost reporting period shall be the applicable percentage increase (as so defined, as amended by subsection (a)); and

''(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been the applicable percentage increase (as so defined, as amended by subsection (a)).

''(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

''(A) the amendments made by subsection (e) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987;

''(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1988, payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)] were equal to the product of 2.7 percent and the ratio of 315 to 366; and

''(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1988 shall be deemed to have been 2.7 percent.

''(4) DEFINITION, REGIONAL FLOOR, AND TECHNICAL AND CONFORMING AMENDMENTS.—The amendments made by subsections (b) and (d) and paragraphs (1) and (2) of subsection (f) [amending this section and provisions set out as a note below] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

''(5) TRANSITION FOR LARGE URBAN AREA RATES.—In computing the average standardized amount for hospitals located in a large urban area or other urban area under section 1886(d)(3)(A)(ii) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(A)(ii)] (as amended by subsection (c)) for fiscal year 1988, the reference to 'the respective average standardized amount computed for the previous fiscal year under this subparagraph' is deemed a reference to the average standardized amount computed for hospitals located in an urban area for the 51-day period beginning on October 1, 1987.

''(6) DEFINITION.—In this subsection, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)].''

Pub. L. 100–203, title IV, § 4003(e), Dec. 22, 1987, 101 Stat. 1330–47, provided that: ''The amendments made by this section [amending this section] shall apply to payments for discharges occurring on or after October 1, 1988.''

Pub. L. 100–203, title IV, § 4005(a)(3), Dec. 22, 1987, 101 Stat. 1330–48, as amended by Pub. L. 100–360, title IV, § 411(b)(4)(C)(ii), July 1, 1988, 102 Stat. 770, provided that: ''This subsection [amending this section] shall apply to discharges occurring on or after October 1, 1988.''

Pub. L. 100–203, title IV, § 4005(c)(2)(A), Dec. 22, 1987, 101 Stat. 1330–49, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987[.]''

Pub. L. 100–203, title IV, § 4005(d)(1)(B), Dec. 22, 1987, 101 Stat. 1330–49, provided that: ''The amendment made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after April 1, 1988.''

Pub. L. 100–203, title IV, § 4006(b)(3), Dec. 22, 1987, 101 Stat. 1330–53, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 1987. The amendments made by paragraph

(2) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987.''

Pub. L. 100–203, title IV, §4007(b)(2), Dec. 22, 1987, 101 Stat. 1330–53, as amended by Pub. L. 100–360, title IV, §411(b)(6)(B), July 1, 1988, 102 Stat. 770, provided that: ''The amendment made by paragraph (1)(C) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1989.''

Pub. L. 100–203, title IV, §4009(d)(2), Dec. 22, 1987, 101 Stat. 1330–57, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to appointments made after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, §4009(j)(6), Dec. 22, 1987, 101 Stat. 1330–59, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, §4083(b)(2), Dec. 22, 1987, 101 Stat. 1330–129, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].''

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, §1895(b)(1)(D), Oct. 22, 1986, 100 Stat. 2932, which provided for applicability of amendments to this section by section 1895(b)(1) of Pub. L. 99–514 to discharges occurring on or after Oct. 1, 1986, with certain exceptions, was repealed by Pub. L. 99–509, title IX, §9307(c)(1)(A), Oct. 21, 1986, 100 Stat. 1995, and by Pub. L. 100–647, title I, §1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Pub. L. 99–514, title XVIII, §1895(b)(2)(b), formerly §1895(b)(2)(D), Oct. 22, 1986, 100 Stat. 2932, as amended by Pub. L. 99–509, title IX, §9307(c)(1)(B)(iii), as amended by Pub. L. 100–203, title IV, §4009(j)(6)(A), Dec. 22, 1987, 101 Stat. 1330–59, which provided for applicability of amendments to this section by section 1895(b)(2)(A) of Pub. L. 99–514 to discharges occurring on or after May 1, 1986, was repealed by Pub. L. 100–647, title I, §1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Amendment by section 1895(b)(3), (9) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9302(a)(3), Oct. 21, 1986, 100 Stat. 1982, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], for cost reporting periods beginning and discharges occurring on or after October 1, 1986.''

Pub. L. 99–509, title IX, §9302(b)(2), Oct. 21, 1986, 100 Stat. 1982, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1986.''

Pub. L. 99–509, title IX, §9302(d)(1)(B), Oct. 21, 1986, 100 Stat. 1983, provided that:

''(i) Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall apply to payments for discharges occurring on or after October 1, 1986.

''(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986.''

Pub. L. 99–509, title IX, §9303(b), Oct. 21, 1986, 100 Stat. 1985, provided that the amendment made by such section 9303(b) is effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after Oct. 1, 1987.

Pub. L. 99–509, title IX, §9304(d), Oct. 21, 1986, 100 Stat. 1988, provided that: ''The amendments made by this section [amending this section] shall apply to discharges occurring on or after October 1, 1987.''

Pub. L. 99–509, title IX, §9306(d), Oct. 21, 1986, 100 Stat. 1995, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall apply to discharges occurring on or after October 1, 1986.''

Pub. L. 99–509, title IX, §9307(c)(1), Oct. 21, 1986, 100 Stat. 1995, provided that the amendment made by such section 9307(c)(1) is effective as if included in the enactment of the Tax Reform Act of 1986 (Pub. L. 99–514), if H.Con.Res. 395, 99th Congress, 2d Session, is not adopted. H.Con.Res. 395 was not adopted.

Pub. L. 99–509, title IX, §9314(b), Oct. 21, 1986, 100 Stat. 2005, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payments for approved residency training programs as of July 1, 1987.''

Amendment by section 9320(g) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9321(e)(3)(B), Oct. 21, 1986, 100 Stat. 2018, provided that: ''The amendments made by paragraph (2) [amending this section] shall take effect beginning with fiscal year 1989.''

Pub. L. 99–272, title IX, §9101(d), Apr. 7, 1986, 100 Stat. 154, provided that: ''The amendment made by subsection (a) [amending section 5(c) of Pub. L. 99–107, set out below] shall take effect on March 15, 1986, and the amendments made by subsection (c) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].''

Pub. L. 99–272, title IX, §9101(e), Apr. 7, 1986, 100 Stat. 154, provided that:

''(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (4))—

''(A) the amendment made by subsection (b) [amending this section] shall apply to payments made under section 1886(d)(1)(A) of such Act [42 U.S.C. 1395ww(d)(1)(A)] made on the basis of discharges occurring on or after May 1, 1986; and

''(B) for discharges occurring on or after October 1, 1986, the applicable percentage increase (described in section 1886(b)(3)(B) [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1986 shall be deemed to have been ½ percent.

''(2) PPS HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital—

''(A) the amendment made by subsection (b) [amending this section] shall apply to payments under section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)] made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting periods beginning on or after October 1, 1985;

''(B) notwithstanding subparagraph (A), for the cost reporting period beginning during fiscal year 1986, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for the—

''(i) first 7 months of the cost reporting period shall be 0 percent, and

''(ii) for the remaining 5 months of the cost reporting period shall be ½ percent; and

''(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been ½ percent.

''(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

''(A) the amendment made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985;

''(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal

year 1986, payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) [42 U.S.C. 1395ww(b)(3)(B)] were equal to 5/24 of 1 percent; and

''(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been ½ percent.

''(4) DEFINITION.—In this subsection, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)].''

Pub. L. 99–272, title IX, § 9102(d), Apr. 7, 1986, 100 Stat. 155, provided that:

''(1) DELAY IN FINAL TRANSITION.—The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].''

''(2) CHANGE IN HOSPITAL SPECIFIC PERCENTAGE.—The amendments made by subsection (b) [amending this section] shall apply—

''(A) to cost reporting periods beginning on or after October 1, 1985, but

''(B) notwithstanding subparagraph (A), for a hospital's cost reporting period beginning during fiscal year 1986, for purposes of section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)]—

''(i) during the first 7 months of the period the 'target percentage' is 50 percent and the 'DRG percentage' is 50 percent, and

''(ii) during the remaining 5 months of the period the 'target percentage' is 45 percent and the 'DRG percentage' is 55 percent.

''(3) CHANGE IN BLENDED RATE.—The amendments made by subsection (c) [amending this section] shall apply to discharges occurring on or after May 1, 1986.

''(4) EXCEPTION.—

''(A) Notwithstanding any other provision of this subsection, the amendments made by this section [amending this section] shall not apply to payments with respect to the operating costs of inpatient hospital services (as defined in section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)]) of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)]) located in the State of Oregon.

''(B) Notwithstanding any other provision of law, for a cost reporting period beginning during fiscal year 1986 of a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply, for purposes of section 1886(d)(1)(A) of of [sic] Social Security Act [42 U.S.C. 1395ww(d)(1)(A)]—

''(i) during the first 7 months of the period the 'target percentage' is 50 percent and the 'DRG percentage' is 50 percent, and

''(ii) during the remaining 5 months of the period the 'target percentage' is 25 percent and the 'DRG percentage' is 75 percent.

''(C) Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(D) of such Act [42 U.S.C. 1395ww(d)(1)(D)], the applicable combined adjusted DRG prospective payment rate for a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply is, for discharges occurring on or after October 1, 1985, and before May 1, 1986, a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate and 75 percent of the regional adjusted DRG prospective payment rate for such discharges.''

Pub. L. 99–272, title IX, § 9104(c), Apr. 7, 1986, 100 Stat. 158, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986.

''(2) The amendments made by this section shall not first be applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105 [amending this section] are also being applied.''

Pub. L. 99–272, title IX, § 9105(e), Apr. 7, 1986, 100 Stat. 160, provided that: ''The amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986.''

Pub. L. 99–272, title IX, § 9106(b), Apr. 7, 1986, 100 Stat. 160, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 1986.''

Pub. L. 99–272, title IX, § 9107(c)(1), Apr. 7, 1986, 100 Stat. 161, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1986.''

Pub. L. 99–272, title IX, § 9109(b), Apr. 7, 1986, 100 Stat. 162, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].''

Pub. L. 99–272, title IX, § 9111(b), Apr. 7, 1986, 100 Stat. 162, provided that: ''The amendment made by this section [amending this section] shall apply to payments for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989.''

Pub. L. 99–272, title IX, § 9202(b), Apr. 7, 1986, 100 Stat. 175, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after July 1, 1985.''

EFFECTIVE AND TERMINATION DATES OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, § 2307(b)(2), July 18, 1984, 98 Stat. 1074, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984.''

Pub. L. 98–369, div. B, title III, § 2310(b), July 18, 1984, 98 Stat. 1075, provided that: ''The amendments made by this section [amending this section] shall apply to cost reporting periods beginning in, and discharges occurring in, fiscal year 1985 and thereafter.''

Pub. L. 98–369, div. B, title III, § 2311(d), July 18, 1984, 98 Stat. 1077, provided that:

''(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1983, and the amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1984.

''(2) The amendment made by subsection (b) [amending this section] shall not apply so as to reduce any payment under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to a hospital the region of which is deemed to be changed pursuant to such amendment for discharges occurring in any cost reporting period beginning before October 1, 1984.''

Pub. L. 98–369, div. B, title III, § 2312(c), July 18, 1984, 98 Stat. 1078, as amended by Pub. L. 99–509, title IX, § 9320(a), Oct. 21, 1986, 100 Stat. 2013; Pub. L. 100–360, title IV, § 411(p), July 1, 1988, as added by Pub. L. 100–485, title VI, § 608(d)(29), Oct. 13, 1988, 102 Stat. 2424, provided that: ''The amendments made by subsections (a) and (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984, and before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.''

Amendment by section 2313(a), (b), (d) of Pub. L. 98–369 effective July 18, 1984, see section 2313(e) of Pub.

L. 98–369, set out as an Effective Date of 1984 Amendment note under section 1395y of this title.

Pub. L. 98–369, div. B, title III, § 2315(g), July 18, 1984, 98 Stat. 1080, provided that: ''The amendments made by this section [amending this section and sections 1395i–2 and 1395cc of this title and enacting and amending provisions set out as notes under this section] shall be effective as though they had been included in the enactment of the Social Security Amendments of 1983 (Public Law 98–21).''

Amendment by section 2354(b)(42)–(44) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as an Effective Date of 1984 Amendment note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title VI, § 601(b)(9), Apr. 20, 1983, 97 Stat. 150, provided that the repeal of subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1982, and that the enactment of a new subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1983.

Pub. L. 98–21, title VI, § 604, Apr. 20, 1983, 97 Stat. 168, as amended by Pub. L. 98–369, div. B, title III, § 2315(f)(1), July 18, 1984, 98 Stat. 1080, provided that:

''(a)(1) Except as provided in section 602(*l*) [amending section 1395cc of this title] and in paragraph (2), the amendments made by the preceding provisions of this title [amending this section and sections 1320c–2, 1395f, 1395n, 1395x, 1395y, 1395cc, 1395mm, 1395*oo*, 1395rr, and 1395xx of this title] apply to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1983. A change in a hospital's cost reporting period that has been made after November 1982 shall be recognized for purposes of this section only if the Secretary finds good cause for that change.

''(2) Section 1866(a)(1)(F) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(F)] (as added by section 602(f)(1)(C) of this title), section 1862(a)(14) [42 U.S.C. 1395y(a)(14)] (as added by section 602(e)(3) of this title) and sections 1886(a)(1)(G) and (H) of such Act [probably should be section 1866(a)(1)(G) and (H), 42 U.S.C. 1395cc(a)(1)(G), (H)] (as added by section 602(f)(1)(C) of this title) take effect on October 1, 1983.

''(b) The Secretary shall make an appropriate reduction in the payment amount under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] (as amended by this title) for any discharge, if the admission has occurred before a hospital's first cost reporting period that begins after September 1983, to take into account amounts payable under title XVIII of that Act [42 U.S.C. 1395 et seq.] (as in effect before the date of the enactment of this Act [Apr. 20, 1983]) for items and services furnished before that period.

''(c)(1) The Secretary shall cause to be published in the Federal Register a notice of the interim final DRG prospective payment rates established under subsection (d) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(d)] (as amended by this title) no later than September 1, 1983, and allow for a period of public comment thereon. Payment on the basis of prospective rates shall become effective on October 1, 1983, without the necessity for consideration of comments received, but the Secretary shall, by notice published in the Federal Register, affirm or modify the amounts by December 31, 1983, after considering those comments.

''(2) A modification under paragraph (1) that reduces a prospective payment rate shall apply only to discharges occurring after 30 days after the date the notice of the modification is published in the Federal Register.

''(3) Rules to implement the amendments made by this title [amending this section and sections 1320a–1, 1320c–2, 1395f, 1395i–2, 1395n, 1395r, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395*oo*, 1395rr, and 1395xx of this title, enacting provisions set out as notes under sections 1395r and 1395x of this title, and amending provisions set out as a note under section 1395x of this title] shall be established in accordance with the procedure described in this subsection.''

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, § 101(b)(1), Sept. 3, 1982, 96 Stat. 335, provided that: ''The amendments made by subsection (a) [enacting this section and amending section 1395x of this title] shall apply to cost reporting periods beginning on or after October 1, 1982.''

REGULATIONS

Pub. L. 101–508, title IV, § 4003(c), Nov. 5, 1990, 104 Stat. 1388–39, provided that: ''The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this section [amending this section and enacting provisions set out as a note above].''

Pub. L. 98–369, div. B, title III, § 2315(f)(2), July 18, 1984, 98 Stat. 1080, provided that: ''Notwithstanding section 604(c) of the Social Security Amendments of 1983 [section 604(c) of Pub. L. 98–21, set out above], the Secretary of Health and Human Services shall cause to be published in the Federal Register proposed regulations to carry out subsection (c) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(c)] not later than July 1, 1984, and allow for a period of 45 days for public comment thereon. After consideration of the comments received, the Secretary shall cause to be published in the Federal Register final regulations to carry out such subsection not later than October 1, 1984.''

Pub. L. 97–248, title I, § 101(b)(2)(A), Sept. 3, 1982, 96 Stat. 335, provided that: ''The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement such amendments [amendments by section 101(a) of Pub. L. 97–248, enacting this section and amending section 1395x of this title] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than March 31, 1983.''

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–192, title I, § 102(e), June 25, 2010, 124 Stat. 1282, provided that: ''Nothing in the amendments made by this section [amending this section] shall be construed as changing the policy described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as applied by the Secretary of Health and Human Services before the date of the enactment of this Act [June 25, 2010], with respect to diagnostic services.''

Pub. L. 111–148, title V, § 5504(c), Mar. 23, 2010, 124 Stat. 660, provided that: ''The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).''

Pub. L. 111–148, title V, § 5505(d), title X, § 10501(j), Mar. 23, 2010, 124 Stat. 999, provided that: ''The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not

a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).''

Pub. L. 111–148, title V, § 5506(c), Mar. 23, 2010, 124 Stat. 662, provided that: ''The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section [sic] 1395ww(h)).''

TRANSFER OF FUNCTIONS

Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

IMPLEMENTATION OF AMENDMENT BY PUB. L. 116–136

Pub. L. 116–136, div. A, title III, § 3710(b), Mar. 27, 2020, 134 Stat. 422, provided that: ''Notwithstanding any other provision of law, the Secretary [probably means Secretary of Health and Human Services] may implement the amendment made by subsection (a) [amending this section] by program instruction or otherwise.''

INCREASING ACCESS TO POST-ACUTE CARE DURING EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, § 3711, Mar. 27, 2020, 134 Stat. 422, provided that:

''(a) WAIVER OF IRF 3-HOUR RULE.—With respect to inpatient rehabilitation services furnished by a rehabilitation facility described in section 1886(j)(1) of the Social Security Act (42 U.S.C. 1395ww(j)(1)) during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall waive section 412.622(a)(3)(ii) of title 42, Code of Federal Regulations (or any successor regulations), relating to the requirement that patients of an inpatient rehabilitation facility receive at least 15 hours of therapy per week.

''(b) WAIVER OF SITE-NEUTRAL PAYMENT RATE PROVISIONS FOR LONG-TERM CARE HOSPITALS.—With respect to inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall waive the following provisions of section 1886(m)(6) of such Act (42 U.S.C. 1395ww(m)(6)):

''(1) LTCH 50-PERCENT RULE.—Subparagraph (C)(ii) of such section, relating to the payment adjustment for long-term care hospitals that do not have a discharge payment percentage for the period that is at least 50 percent.

''(2) SITE-NEUTRAL IPPS PAYMENT RATE.—Subparagraph (A)(i) of such section, relating to the application of the site-neutral payment rate (and payment shall be made to a long-term care hospital without regard to such section) for a discharge if the admission occurs during such emergency period and is in response to the public health emergency described in such section 1135(g)(1)(B).''

APPLICATION OF CHANGE IN MEDICARE CLASSIFICATION FOR CERTAIN HOSPITALS

Pub. L. 114–255, div. C, title XV, § 15008(c), Dec. 13, 2016, 130 Stat. 1321, provided that:

''(1) IN GENERAL.—For cost reporting periods beginning on or after January 1, 2015, in the case of an applicable hospital (as defined in paragraph (3) [sic, probably should be ''paragraph (2)'']), the following shall apply:

''(A) Payment for inpatient operating costs shall be made on a reasonable cost basis in the manner provided in section 412.526(c)(3) of title 42, Code of Federal Regulations (as in effect on January 1, 2015) and in any subsequent modifications.

''(B) Payment for capital costs shall be made in the manner provided by section 412.526(c)(4) of title 42, Code of Federal Regulations (as in effect on such date).

''(C) Claims for payment for Medicare beneficiaries who are discharged on or after January 1, 2017, shall be processed as claims which are paid on a reasonable cost basis as described in section 412.526(c) of title 42, Code of Federal Regulations (as in effect on such date).

''(2) APPLICABLE HOSPITAL DEFINED.—In this subsection, the term 'applicable hospital' means a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) on the day before the date of the enactment of this Act [Dec. 13, 2016] and which is classified under clause (vi) of such section, as redesignated and moved by subsection (a), on or after such date of enactment.''

IMPLEMENTATION OF AMENDMENT BY PUB. L. 114–113

Pub. L. 114–113, div. O, title VI, § 602(c), Dec. 18, 2015, 129 Stat. 3024, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395w–23 of this title] by program instruction or otherwise.''

CALCULATION OF LENGTH OF STAY EXCLUDING CASES PAID ON A SITE NEUTRAL BASIS

Pub. L. 113–67, div. B, title II, § 1206(a)(3), Dec. 26, 2013, 127 Stat. 1203, as amended by Pub. L. 113–93, title I, § 112(c)(2), Apr. 1, 2014, 128 Stat. 1045; Pub. L. 114–255, div. C, title XV, § 15007(a), Dec. 13, 2016, 130 Stat. 1320, provided that: ''For discharges occurring in cost reporting periods beginning on or after October 1, 2015, in calculating the length of stay requirement applicable to a long-term care hospital or satellite facility under section 1886(d)(1)(B)(iv)(I) [now 1886(d)(1)(B)(iv)] of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I) [1395ww(d)(1)(B)(iv)]) and section 1861(ccc)(2) of such Act (42 U.S.C. 1395x(ccc)(2)), the Secretary of Health and Human Services shall exclude the following:

''(A) SITE NEUTRAL PAYMENT.—Any patient for whom payment is made at the site neutral payment rate (as defined in section 1886(m)(6)(B)(ii) [42 U.S.C. 1395ww(m)(6)(B)(ii)) of such Act, as added by paragraph (1)).

''(B) MEDICARE ADVANTAGE.—Any patient for whom payment is made under a Medicare Advantage plan under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.].''

[Pub. L. 114–255, div. C, title XV, § 15007(b), Dec. 13, 2016, 130 Stat. 1320, provided that: ''The amendments made by subsection (a) [amending section 1206(a)(3) of Pub. L. 113–67, set out above] shall be effective as if included in the enactment of section 1206(a)(3) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67; 42 U.S.C. 1395ww note).'']

REVIEW OF TREATMENT OF CERTAIN LTCHS

Pub. L. 113–67, div. B, title II, § 1206(d), Dec. 26, 2013, 127 Stat. 1204, provided that:

''(1) EVALUATION.—As part of the annual rulemaking for fiscal year 2015 or fiscal year 2016 to carry out the

payment rates under subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall evaluate both the payment rates and regulations governing hospitals which are classified under subclause (II) of subsection (d)(1)(B)(iv) of such section.

''(2) ADJUSTMENT AUTHORITY.—Based upon such evaluation, the Secretary may adjust payment rates under subsection (b)(3) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital so classified (such as payment based upon the TEFRA-payment model) and may adjust the regulations governing such hospitals, including applying the regulations governing hospitals which are classified under clause (I) of subsection (d)(1)(B) of such section.''

SPECIAL RULE FOR FISCAL YEAR 2011 AND ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011

Pub. L. 111–309, title I, §102(a)(2), (3), Dec. 15, 2010, 124 Stat. 3286, provided that:

''(2) SPECIAL RULE FOR FISCAL YEAR 2011.—

''(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1) [amending section 106(a) of div. B of Pub. L. 109–432, set out as a note under this section], including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out as a note under this section], as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 16, 2010 (75 Fed. Reg. 50042), and any subsequent corrections.

''(B) EXCEPTION.—Beginning on April 1, 2011, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this subparagraph shall not be effected in a budget neutral manner.

''(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011.—

''(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

''(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

''(ii) the wage index applicable for such hospital for the period beginning on October 1, 2010, and ending on March 31, 2011, was lower than for the period beginning on April 1, 2011, and ending on September 30, 2011, by reason of the application of paragraph (2)(B);

''the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

''(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph (A) by not later than December 31, 2011.''

Similar provisions were contained in Pub. L. 111–148, title III, §3137(a)(2), (3), title X, §10317, Mar. 23, 2010, 124 Stat. 438, 947.

NO REOPENING OF PREVIOUSLY BUNDLED CLAIMS

Pub. L. 111–192, title I, §102(c), June 25, 2010, 124 Stat. 1281, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services may not reopen a claim, adjust a claim, or make a payment pursuant to any request for payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital) for services described in paragraph (2) for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission.

''(2) SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this paragraph are other services related to the admission (as described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as amended by subsection (a)) which were previously included on a claim or request for payment submitted under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] for which a reopening, adjustment, or request for payment under part B of such title [42 U.S.C. 1395j et seq.], was not submitted prior to the date of the enactment of this Act [June 25, 2010].''

IMPLEMENTATION OF AMENDMENT BY PUB. L. 111–192

Pub. L. 111–192, title I, §102(d), June 25, 2010, 124 Stat. 1281, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of this section [amending this section and enacting provisions set out as notes under this section] (and amendments made by this section) by program instruction or otherwise.''

PAYMENT FOR QUALIFYING HOSPITALS

Pub. L. 111–152, title I, §1109, Mar. 30, 2010, 124 Stat. 1051, provided that:

''(a) IN GENERAL.—From the amount available under subsection (b), the Secretary of Health and Human Services shall provide for a payment to qualifying hospitals (as defined in subsection (d)) for fiscal years 2011 and 2012 of the amount determined under subsection (c).

''(b) AMOUNTS AVAILABLE.—There shall be available from the Federal Hospital Insurance Trust Fund $400,000,000 for payments under this section for fiscal years 2011 and 2012.

''(c) PAYMENT AMOUNT.—The amount of payment under this section for a qualifying hospital shall be determined, in a manner consistent with the amount available under subsection (b), in proportion to the portion of the amount of the aggregate payments under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to the hospital for fiscal year 2009 bears to the sum of all such payments to all qualifying hospitals for such fiscal year.

''(d) QUALIFYING HOSPITAL DEFINED.—In this section, the term 'qualifying hospital' means a subsection (d) hospital (as defined for purposes of section 1886(d) of the Social Security Act) that is located in a county that ranks, based upon its ranking in age, sex, and race adjusted spending for benefits under parts A and B under title XVIII of such Act [42 U.S.C. 1395c et seq.; 42 U.S.C. 1395j et seq.] per enrollee, within the lowest quartile of such counties in the United States.''

VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS

Pub. L. 111–148, title III, §3001(b), Mar. 23, 2010, 124 Stat. 362, provided that:

''(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

''(A) ESTABLISHMENT.—

''(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of

such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

''(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

''(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

''(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

''(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section [amending this section and enacting this note], the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

''(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

''(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

''(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

''(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

''(A) ESTABLISHMENT.—

''(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

''(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term 'applicable hospital' means a hospital described in subclause (III) or (IV) of section 1886(*o*)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395ww(*o*)(1)(C)(ii)], as added by subsection (a)(1).

''(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

''(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

''(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

''(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

''(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

''(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

''(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.''

REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

Pub. L. 111–148, title III, § 3137(b), (c), Mar. 23, 2010, 124 Stat. 438, 439, provided that:

''(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act [42 U.S.C. 1395ww].

''(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled 'Report to Congress: Promoting Greater Efficiency in Medicare', including establishing a new hospital compensation index system that—

''(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

''(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

''(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

''(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

''(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

''(F) provides for a transition.

''(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

''(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))[)] for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.''

APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR

Pub. L. 111–148, title III, § 3141, Mar. 23, 2010, 124 Stat. 441, provided that: ''In the case of discharges occurring

on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 [section 4410 of Pub. L. 105–33, set out as a note under this section] (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).''

EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS

Pub. L. 111–148, title V, §5506(d), Mar. 23, 2010, 124 Stat. 662, provided that: ''The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section [amending this section] on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act [Mar. 23, 2010]) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).''

GRADUATE NURSE EDUCATION DEMONSTRATION

Pub. L. 111–148, title V, §5509, Mar. 23, 2010, 124 Stat. 674, provided that:

''(a) IN GENERAL.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

''(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

''(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

''(2) COSTS DESCRIBED.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

''(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

''(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration.

''(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

''(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

''(1) the obligations of the eligible partners with respect to the provision of qualified training; and

''(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

''(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

''(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

''(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

''(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

''(4) Other items the Secretary determines appropriate and relevant.

''(d) FUNDING.—

''(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

''(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

''(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

''(e) DEFINITIONS.—In this section:

''(1) ADVANCED PRACTICE REGISTERED NURSE.—The term 'advanced practice registered nurse' includes the following:

''(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

''(B) A nurse practitioner (as defined in such subsection).

''(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

''(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

''(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term 'applicable non-hospital community-based care setting' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

''(3) APPLICABLE SCHOOL OF NURSING.—The term 'applicable school of nursing' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act [42 U.S.C. 296]) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

''(4) DEMONSTRATION.—The term 'demonstration' means the graduate nurse education demonstration established under subsection (a).

''(5) ELIGIBLE HOSPITAL.—The term 'eligible hospital' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

''(A) 1 or more applicable schools of nursing; and

''(B) 2 or more applicable non-hospital community-based care settings.

''(6) ELIGIBLE PARTNERS.—The term 'eligible partners' includes the following:

''(A) An applicable non-hospital community-based care setting.

''(B) An applicable school of nursing.

''(7) QUALIFIED TRAINING.—

''(A) IN GENERAL.—The term 'qualified training' means training—

''(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.]; and

''(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

''(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

''(8) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.''

PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES

Pub. L. 110–173, title I, §114(c), Dec. 29, 2007, 121 Stat. 2502, as amended by Pub. L. 111–5, div. B, title IV, §4302(a), Feb. 17, 2009, 123 Stat. 495; Pub. L. 111–148, title III, §3106(a), title X, §10312(a), Mar. 23, 2010, 124 Stat. 418, 943; Pub. L. 113–67, div. B, title II, §1206(b)(1)(A), (B), Dec. 26, 2013, 127 Stat. 1203; Pub. L. 114–255, div. C, title XV, §15006, Dec. 13, 2016, 130 Stat. 1320, provided that:

''(1) DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT.—The Secretary [of Health and Human Services] shall not apply, for cost reporting periods beginning on or after July 1, 2007,— [sic]

''(A) through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before October 1, 2017, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals or to a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] at the off-campus location; and

''(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33) [amending this section and enacting provisions set out as a note under this section].

''(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

''(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, or any similar provision, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

''(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

''(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, or any similar provision, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

''(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term 'applicable long-term care hospital or satellite facility' means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations, or any similar provision, or that is described in section 412.22(h)(3)(i) of such title.

''(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations) through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before October 1, 2017.

''(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

''(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.''

[Pub. L. 111–5, div. B, title IV, §4302(c), Feb. 17, 2009, 123 Stat. 496, provided that: ''The amendments made by this section [amending Pub. L. 110–173, §114(c), set out above, and Pub. L. 110–173, §114(d), set out below] shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173).'']

MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES

Pub. L. 110–173, title I, §114(d), Dec. 29, 2007, 121 Stat. 2503, as amended by Pub. L. 111–5, div. B, title IV, §4302(b), Feb. 17, 2009, 123 Stat. 496; Pub. L. 111–148, title III, §3106(b), title X, §10312(b), Mar. 23, 2010, 124 Stat. 418, 943; Pub. L. 113–67, div. B, title II, §1206(b)(2), Dec. 26, 2013, 127 Stat. 1204; Pub. L. 113–93, title I, §112(b), Apr. 1, 2014, 128 Stat. 1044; Pub. L. 114–255, div. C, title XV, §15004(a)(1), Dec. 13, 2016, 130 Stat. 1319, provided that:

''(1) IN GENERAL.—During the 5-year period (and for the period beginning on the date of the enactment of paragraph (7) of this subsection [Apr. 1, 2014] and ending September 30, 2017) beginning on the date of the enactment of this Act [Dec. 29, 2007], the Secretary [of Health and Human Services] shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]—

''(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

''(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

''(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

''(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title

42, Code of Federal Regulations, on or before the date of the enactment of this Act;

''(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

''(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

''(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

''(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility—

''(i) is located in a State where there is only one other long-term care hospital; and

''(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

''(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

''(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term 'existing' means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

''(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395*oo*), or otherwise, of the application of this subsection by the Secretary.

''(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning on the date of the enactment of paragraph (7) of this subsection [Apr. 1, 2014] and ending September 30, 2017.

''(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—Any moratorium under paragraph (1) shall not apply to a long-term care hospital that—

''(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph [Apr. 1, 2014];

''(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

''(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment.''

[Pub. L. 114–255, div. C, title XV, §15004(a)(2), Dec. 13, 2016, 130 Stat. 1319, provided that: ''The amendment made by paragraph (1) [amending section 114(d) of Pub. L. 110–173, set out above] shall take effect as if included in the enactment of section 112 of the Protecting Access to Medicare Act of 2014 [Pub. L. 113–93, amending section 114(d) of Pub. L. 110–173, set out above].'']

[For effective date of amendment by Pub. L. 111–5, see section 4302(c) of Pub. L. 111–5, set out as a note following section 114(c) of Pub. L. 110–173, set out above.]

EXPANDED REVIEW OF MEDICAL NECESSITY

Pub. L. 110–173, title I, §114(f), Dec. 29, 2007, 121 Stat. 2505, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G) [now 42 U.S.C. 1395kk–1(a)(4)(H)]), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act [42 U.S.C. 1395ww(d)(1)(B)(iv)]) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

''(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

''(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

''(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

''(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

''(4) TERMINATION OF REQUIRED REVIEWS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

''(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

''(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.''

EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS

Pub. L. 110–173, title I, §117(a)(2), (3), Dec. 29, 2007, 121 Stat. 2507, as amended by Pub. L. 110–275, title I, §124(b), July 15, 2008, 122 Stat. 2518; Pub. L. 111–309, title I, §102(b), Dec. 15, 2010, 124 Stat. 3287, provided that:

''(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109–432) [set out below], the special exception reclassifications made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

''(3) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of this subsection [par. (1) of this subsection amended section 106(a) of Pub. L. 109–432, set out below] in fiscal years 2008 and 2009, the Secretary

shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on October 10, 2007 (72 Fed. Reg. 57634), and any subsequent corrections.''

CORRECTION OF APPLICATION OF WAGE INDEX DURING TAX RELIEF AND HEALTH CARE ACT EXTENSION

Pub. L. 110–173, title I, § 117(c), Dec. 29, 2007, 121 Stat. 2508, provided that: ''In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

''(1) a reclassification of its wage index for purposes of such section was extended for the period beginning on April 1, 2007, and ending on September 30, 2007, pursuant to subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 [Pub. L. 109–432] (42 U.S.C. 1395[ww] note); and

''(2) the wage index applicable for such hospital during such period was lower than the wage index applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007,

the Secretary [of Health and Human Services] shall apply the higher wage index that was applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, for the entire fiscal year 2007. If the Secretary determines that the application of the preceding sentence to a hospital will result in a hospital being owed additional reimbursement, the Secretary shall make such payments within 90 days after the settlement of the applicable cost report.''

CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION

Pub. L. 109–432, div. B, title I, § 106(a), Dec. 20, 2006, 120 Stat. 2982, as amended by Pub. L. 110–173, title I, § 117(a)(1), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, § 124(a), July 15, 2008, 122 Stat. 2518; Pub. L. 111–148, title III, § 3137(a)(1), title X, § 10317, Mar. 23, 2010, 124 Stat. 438, 947; Pub. L. 111–309, title I, § 102(a)(1), Dec. 15, 2010, 124 Stat. 3286; Pub. L. 112–78, title III, § 302(a), Dec. 23, 2011, 125 Stat. 1284; Pub. L. 112–96, title III, § 3001(a), Feb. 22, 2012, 126 Stat. 185, provided that: ''Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through March 31, 2012. The previous sentence shall not be effected in a budget-neutral manner.''

[Pub. L. 112–96, title III, § 3001(b), (c)(1), Feb. 22, 2012, 126 Stat. 185, provided that:

[''(b) SPECIAL RULE.—

[''(1) IN GENERAL.—Subject to paragraph (2), for purposes of implementation of the amendment made by subsection (a) [amending section 106(a) of Pub. L. 109–432, set out above], including for purposes of the implementation of paragraph (2) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out above], for the period beginning on December 1, 2011, and ending on March 31, 2012, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 18, 2011 (76 Fed. Reg. 51476), and any subsequent corrections.

[''(2) EXCEPTION.—In determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall, for the period described in paragraph (1), include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by subsection (a) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this paragraph shall not be effected in a budget neutral manner.

[''(c) TIMEFRAME FOR PAYMENTS.—

[''(1) IN GENERAL.—The Secretary shall make payments required under subsections (a) and (b) by not later than June 30, 2012.'']

[Pub. L. 112–78, title III, § 302(b), (c), Dec. 23, 2011, 125 Stat. 1284, as amended by Pub. L. 112–96, title III, § 3001(c)(2), Feb. 22, 2012, 126 Stat. 185, provided that:

[''(b) SPECIAL RULE FOR OCTOBER AND NOVEMBER 2011.—

[''(1) IN GENERAL.—Subject to paragraph (2), for purposes of implementation of the amendment made by subsection (a) [amending section 106(a) of Pub. L. 109–432, set out above], including for purposes of the implementation of paragraph (2) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out above], for the period beginning on October 1, 2011, and ending on November 30, 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 18, 2011 (76 Fed. Reg. 51476), and any subsequent corrections.

[''(2) EXCEPTION.—In determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall, for the period beginning on October 1, 2011, and ending on November 30, 2011, include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by subsection (a) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this paragraph shall not be effected in a budget neutral manner.

[''(c) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subsections (a) and (b) by not later than June 30, 2012.'']

PLAN FOR HOSPITAL VALUE BASED PURCHASING PROGRAM

Pub. L. 109–171, title V, § 5001(b), Feb. 8, 2006, 120 Stat. 29, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a plan to implement a value based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009.

''(2) DETAILS.—Such a plan shall include consideration of the following issues:

''(A) The on-going development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.

''(B) The reporting, collection, and validation of quality data.

''(C) The structure of value based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value based payments.

''(D) The disclosure of information on hospital performance.

In developing such a plan, the Secretary shall consult with relevant affected parties and shall consider experience with such demonstrations that are relevant to the value based purchasing program under this subsection.''

EXTENDED PHASE-IN OF THE INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA

Pub. L. 109–171, title V, § 5005, Feb. 8, 2006, 120 Stat. 33, as amended by Pub. L. 110–173, title I, § 115(b)(1), Dec. 29, 2007, 121 Stat. 2506, provided that:

''(a) IN GENERAL.—Notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006, in the classification criterion used under the IRF regulation (as defined in subsection (c)) to determine whether a hospital or unit of a hospital is an inpatient rehabilita-

tion facility under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(b) CONTINUED USE OF COMORBIDITIES.—For cost reporting periods beginning on or after July 1, 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts toward the percent specified in subsection (a).

''(c) IRF REGULATION.—For purposes of subsection (a), the term 'IRF regulation' means the rule published in the Federal Register on May 7, 2004, entitled 'Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility' (69 Fed. Reg. 25752).''

[Pub. L. 110–173, title I, §115(b)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: ''The amendment made by paragraph (1)(A) [amending section 5005(a) of Pub. L. 109–171, set out above] shall apply for cost reporting periods beginning on or after July 1, 2007.'']

MEDICARE DEMONSTRATION PROJECTS TO PERMIT GAINSHARING ARRANGEMENTS

Pub. L. 109–171, title V, §5007, Feb. 8, 2006, 120 Stat. 34, as amended by Pub. L. 111–148, title III, §3027, Mar. 23, 2010, 124 Stat. 415, provided that:

''(a) ESTABLISHMENT.—The Secretary shall establish under this section a qualified gainsharing demonstration program under which the Secretary shall approve demonstration projects by not later than November 1, 2006, to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified in the project. Such projects shall be operational by not later than January 1, 2007.

''(b) REQUIREMENTS DESCRIBED.—A demonstration project under this section shall meet the following requirements for purposes of maintaining or improving quality while achieving cost savings:

''(1) ARRANGEMENT FOR REMUNERATION AS SHARE OF SAVINGS.—The demonstration project shall involve an arrangement between a hospital and a physician under which the hospital provides remuneration to the physician that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician.

''(2) WRITTEN PLAN AGREEMENT.—The demonstration project shall be conducted pursuant to a written agreement that—

''(A) is submitted to the Secretary prior to implementation of the project; and

''(B) includes a plan outlining how the project will achieve improvements in quality and efficiency.

''(3) PATIENT NOTIFICATION.—The demonstration project shall include a notification process to inform patients who are treated in a hospital participating in the project of the participation of the hospital in such project.

''(4) MONITORING QUALITY AND EFFICIENCY OF CARE.—The demonstration project shall provide measures to ensure that the quality and efficiency of care provided to patients who are treated in a hospital participating in the demonstration project is continuously monitored to ensure that such quality and efficiency is maintained or improved.

''(5) INDEPENDENT REVIEW.—The demonstration project shall certify, prior to implementation, that the elements of the demonstration project are reviewed by an organization that is not affiliated with the hospital or the physician participating in the project.

''(6) REFERRAL LIMITATIONS.—The demonstration project shall not be structured in such a manner as to reward any physician participating in the project on the basis of the volume or value of referrals to the hospital by the physician.

''(c) WAIVER OF CERTAIN RESTRICTIONS.—

''(1) IN GENERAL.—An incentive payment made by a hospital to a physician under and in accordance with a demonstration project shall not constitute—

''(A) remuneration for purposes of section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);

''(B) a payment intended to induce a physician to reduce or limit services to a patient entitled to benefits under Medicare or a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] in violation of section 1128A of such Act (42 U.S.C. 1320a–7a); or

''(C) a financial relationship for purposes of section 1877 of such Act (42 U.S.C. 1395nn).

''(2) PROTECTION FOR EXISTING ARRANGEMENTS.—In no case shall the failure to comply with the requirements described in paragraph (1) affect a finding made by the Inspector General of the Department of Health and Human Services prior to the date of the enactment of this Act [Feb. 8, 2006] that an arrangement between a hospital and a physician does not violate paragraph (1) or (2) of section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7(a) [42 U.S.C. 1320a–7a(a)]).

''(d) PROGRAM ADMINISTRATION.—

''(1) SOLICITATION OF APPLICATIONS.—By not later than 90 days after the date of the enactment of this Act [Feb. 8, 2006], the Secretary shall solicit applications for approval of a demonstration project, in such form and manner, and at such time specified by the Secretary.

''(2) NUMBER OF PROJECTS APPROVED.—The Secretary shall approve not more than 6 demonstration projects, at least 2 of which shall be located in a rural area.

''(3) DURATION.—The qualified gainsharing demonstration program under this section shall be conducted for the period beginning on January 1, 2007, and ending on December 31, 2009 (or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008).

''(e) REPORTS.—

''(1) INITIAL REPORT.—By not later than December 1, 2006, the Secretary shall submit to Congress a report on the number of demonstration projects that will be conducted under this section.

''(2) PROJECT UPDATE.—By not later than December 1, 2007, the Secretary shall submit to Congress a report on the details of such projects (including the project improvements towards quality and efficiency described in subsection (b)(2)(B)).

''(3) QUALITY IMPROVEMENT AND SAVINGS.—By not later than March 31, 2011, the Secretary shall submit to Congress a report on quality improvement and savings achieved as a result of the qualified gainsharing demonstration program established under subsection (a).

''(4) FINAL REPORT.—By not later than March 31, 2013, the Secretary shall submit to Congress a final report on the information described in paragraph (3).

''(f) FUNDING.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006 $6,000,000, and for fiscal year 2010, $1,600,000, to carry out this section.

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2014 or until expended.

''(g) DEFINITIONS.—For purposes of this section:

''(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means a project implemented under the qualified gainsharing demonstration program established under subsection (a).

''(2) HOSPITAL.—The term 'hospital' means a hospital that receives payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), and does not include a critical access hospital (as defined in section 1861(mm) of such Act (42 U.S.C. 1395x(mm))).

''(3) MEDICARE.—The term 'Medicare' means the programs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(4) PHYSICIAN.—The term 'physician' means, with respect to a demonstration project, a physician described in paragraph (1) or (3) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) who is licensed as such a physician in the area in which the project is located and meets requirements to provide services for which benefits are provided under Medicare. Such term shall be deemed to include a practitioner described in section 1842(e)(18)(C) of such Act (42 U.S.C. 1395u(e)(18)(C)).

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.''

MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET

Pub. L. 108–173, title IV, § 404, Dec. 8, 2003, 117 Stat. 2266, provided that:

''(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary [of Health and Human Services] shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

''(b) INCORPORATION OF EXPLANATION IN RULEMAKING.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a).''

RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

Pub. L. 108–173, title IV, § 410A, Dec. 8, 2003, 117 Stat. 2272, as amended by Pub. L. 111–148, title III, § 3123, title X, § 10313, Mar. 23, 2010, 124 Stat. 423, 943; Pub. L. 114–255, div. C, title XV, § 15003, Dec. 13, 2016, 130 Stat. 1317; Pub. L. 116–260, div. CC, title I, § 128, Dec. 27, 2020, 134 Stat. 2971, provided that:

''(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

''(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

''(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

''(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period (in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 15-year extension period.

''(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

''(b) PAYMENT.—

''(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

''(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

''(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

''(i) the reasonable costs of providing such services in the cost reporting period involved; or

''(ii) the target amount (as defined in paragraph (2)), applicable to the cost reporting period involved.

''(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term 'target amount' means, with respect to a rural community hospital for a particular 12-month cost reporting period—

''(A) in the case of the second such cost reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

''(B) in the case of a later cost reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

''(c) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

''(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

''(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

''(e) REPORT.—Not later than August 1, 2018, the Secretary shall submit to Congress a report on the demonstration program under this section, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

''(f) DEFINITIONS.—In this section:

''(1) RURAL COMMUNITY HOSPITAL DEFINED.—

''(A) IN GENERAL.—The term 'rural community hospital' means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

''(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

''(ii) subject to subparagraph (B), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

''(iii) makes available 24-hour emergency care services; and

''(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820 of the Social Security Act (42 U.S.C. 1395i–4).

''(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of subparagraph (A)(ii), beds in a psychiatric or rehabilitation unit of the

hospital which is a distinct part of the hospital shall not be counted.

''(2) COVERED INPATIENT HOSPITAL SERVICES.—The term 'covered inpatient hospital services' means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).''

''(g) FIFTEEN-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 15-year (in this section referred to as the '15-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

''(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 15-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

''(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 15-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

''(4) HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM DURING THE INITIAL 5-YEAR PERIOD.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

''(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 15-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

''(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during each 5-year period in such 15-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

''(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of each applicable 5-year period in the 15-year extension period, for

''(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.

''(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—

''(A) CURES ACT EXTENSION.—During the second 5 years of the 15-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

''(B) ADDITIONAL EXTENSION.—During the third 5 years of the 15-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2019, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

''(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

''(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than April 12, 2017, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 15-year extension period without exceeding the limitation under paragraph (3) of this subsection.

''(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

''(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

''(ii) may consider—

''(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

''(II) the population density of the State in which the rural community hospital is located.''

APPLICABILITY OF CHAPTER 35 OF TITLE 44

Pub. L. 108–173, title IV, §422(b)(2), Dec. 8, 2003, 117 Stat. 2286, as amended by Pub. L. 111–148, title V, §5503(c), Mar. 23, 2010, 124 Stat. 659, provided that: ''Chapter 35 of title 44, United States Code, shall not apply with respect to applications under paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(h)(7), (8)][.]''

REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM

Pub. L. 108–173, title IV, §422(c), Dec. 8, 2003, 117 Stat. 2286, provided that: ''Not later than July 1, 2005, the Secretary [of Health and Human Services] shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act [section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) does not contain a subpar. (I)] (as added by subsection (a)).''

MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS

Pub. L. 108–173, title IV, §433, Dec. 8, 2003, 117 Stat. 2288, provided that:

''(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505 [amending this section and sections 1395f, 1395g, 1395i–4, 1395*l*, 1395m, 1395cc, and 1395tt of this title and enacting provisions set out as notes under this section and sections 1395f, 1395g, 1395i–4, 1395*l*, and 1395m of this title]. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

''(b) REPORTS.—

''(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 405 [amending sections 1395f, 1395g, 1395i–4, 1395m, and 1395tt of this title and enacting provisions set out as notes under sections 1395f, 1395g, 1395i–4, and 1395m of this title].

''(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act [Dec. 8, 2003], the

Commission shall submit to Congress a final report on all matters studied under subsection (a).''

GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

Pub. L. 108–173, title V, § 501(c), Dec. 8, 2003, 117 Stat. 2290, provided that:

''(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

''(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

''(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

''(2) REPORT.—Not later than 24 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.''

NOT BUDGET NEUTRAL

Pub. L. 108–173, title V, § 503(d)(2), Dec. 8, 2003, 117 Stat. 2292, provided that: ''There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act [42 U.S.C. 1395ww] because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.''

ONE-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION

Pub. L. 108–173, title V, § 508, Dec. 8, 2003, 117 Stat. 2297, as amended by Pub. L. 110–173, title I, § 117(b), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, § 124(c), July 15, 2008, 122 Stat. 2518, provided that:

''(a) ESTABLISHMENT OF PROCESS.—

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

''(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

''(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act [Dec. 8, 2003] but shall be filed by not later than February 15, 2004.

''(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

''(C) There shall be no further administrative or judicial review of a decision of such Board.

''(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

''(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

''(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

''(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term 'qualifying hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

''(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

''(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

''(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term 'wage index classification' means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

''(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

''(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

''(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for purposes of discharges occurring beginning on October 1, 2007, and ending on the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109–432) [set out above], a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) [div. B of Pub. L. 109–432, set out as a note under this section] shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purpose.''

EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS

Pub. L. 108–173, title VII, § 712, Dec. 8, 2003, 117 Stat. 2340, provided that:

''(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

''(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary [of Health and Human Services] shall promulgate interim final regulations

consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.''

TREATMENT OF VOLUNTEER SUPERVISION

Pub. L. 108–173, title VII, § 713, Dec. 8, 2003, 117 Stat. 2340, provided that:

''(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary [of Health and Human Services] shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

''(b) STUDY AND REPORT.—

''(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.''

FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA

Pub. L. 108–173, title IX, § 951, Dec. 8, 2003, 117 Stat. 2427, provided that: ''Beginning not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] on the basis of such data.''

SPECIAL RULES FOR PAYMENT FOR FISCAL YEAR 2001

Pub. L. 106–554, § 1(a)(6) [title III, § 301(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that: ''Notwithstanding the amendment made by subsection (a) [amending this section], for purposes of making payments for fiscal year 2001 for inpatient hospital services furnished by subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[)], the 'applicable percentage increase' referred to in section 1886(b)(3)(B)(i) of such Act (42 U.S.C. 1395ww(b)(3)(B)(i))—

''(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be determined in accordance with subclause (XVI) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be equal to—

''(A) the market basket percentage increase plus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas; and

''(B) the market basket percentage increase for sole community hospitals.''

Pub. L. 106–554, § 1(a)(6) [title III, § 302(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–493, provided that: ''Notwithstanding paragraph (5)(B)(ii)(V) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined, for discharges occurring on or after April 1, 2001, and before October 1, 2001, as if 'c' in paragraph (5)(B)(ii)(V) of such section equalled 1.66 rather than 1.54.''

Pub. L. 106–554, § 1(a)(6) [title III, § 303(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–493, provided that: ''Notwithstanding the amendment made by subsection (a)(1) [amending this section], for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[)] for fiscal year 2001, the additional payment amount otherwise determined under clause (ii) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

''(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be adjusted as provided by clause (ix)(III) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall, instead of being reduced by 3 percent as provided by clause (ix)(III) of such section as in effect after the date of the enactment of this Act, be reduced by 1 percent.''

Pub. L. 106–554, § 1(a)(6) [title V, § 547(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that:

''(a) INPATIENT HOSPITAL SERVICES.—The payment increase provided under the following sections shall not apply to discharges occurring after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for discharges occurring after such fiscal year:

''(1) Section 301(b)(2)(A) [set out as a note above] (relating to acute care hospital payment update).

''(2) Section 302(b) [set out as a note above] (relating to IME percentage adjustment).

''(3) Section 303(b)(2) [set out as a note above] (relating to DSH payments).''

CONSIDERATION OF PRICE OF BLOOD AND BLOOD PRODUCTS IN MARKET BASKET INDEX

Pub. L. 106–554, § 1(a)(6) [title III, § 301(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that: ''The Secretary of Health and Human Services shall, when next (after the date of the enactment of this Act [Dec. 21, 2000]) rebasing and revising the hospital market basket index (as defined in section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in such index.''

MEDPAC STUDY AND REPORT REGARDING CERTAIN HOSPITAL COSTS

Pub. L. 106–554, § 1(a)(6) [title III, § 301(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on—

''(A) any increased costs incurred by subsection (d) hospitals (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) in providing inpatient hospital services to medicare beneficiaries under title XVIII of such Act [42 U.S.C. 1395 et seq.] during the period beginning on October 1, 1983, and ending on September 30, 1999, that were attributable to—

''(i) complying with new blood safety measure requirements; and

''(ii) providing such services using new technologies;

''(B) the extent to which the prospective payment system for such services under such section provides adequate and timely recognition of such increased costs;

''(C) the prospects for (and to the extent practicable, the magnitude of) cost increases that hos-

pitals will incur in providing such services that are attributable to complying with new blood safety measure requirements and providing such services using new technologies during the 10 years after the date of the enactment of this Act [Dec. 21, 2000]; and

''(D) the feasibility and advisability of establishing mechanisms under such payment system to provide for more timely and accurate recognition of such cost increases in the future.

''(2) CONSULTATION.—In conducting the study under this subsection, the Commission shall consult with representatives of the blood community, including—

''(A) hospitals;

''(B) organizations involved in the collection, processing, and delivery of blood; and

''(C) organizations involved in the development of new blood safety technologies.

''(3) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.''

PROCESS TO PERMIT STATEWIDE WAGE INDEX CALCULATION AND APPLICATION

Pub. L. 106–554, §1(a)(6) [title III, §304(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–494, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process (based on the voluntary process utilized by the Secretary of Health and Human Services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for purposes of computing and applying a statewide geographic adjustment factor) under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)). Such process shall be established by October 1, 2001, for reclassifications beginning in fiscal year 2003.

''(2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLASSIFICATION.—Notwithstanding any other provision of law, if the Secretary applies a statewide geographic wage index under paragraph (1) with respect to a State, any application submitted by a hospital in that State under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)) for geographic reclassification shall not be considered.''

COLLECTION OF INFORMATION ON OCCUPATIONAL MIX

Pub. L. 106–554, §1(a)(6) [title III, §304(c)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–495, provided that: ''The Secretary of Health and Human Services shall provide for the collection of data every 3 years on occupational mix for employees of each subsection (d) hospital (as defined in section 1886(d)(1)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(D))) in the provision of inpatient hospital services, in order to construct an occupational mix adjustment in the hospital area wage index applied under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)).''

Pub. L. 106–554, §1(a)(6) [title III, §304(c)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–495, provided that: ''By not later than September 30, 2003, for application beginning October 1, 2004, the Secretary shall first complete—

''(A) the collection of data under paragraph (1) [set out above]; and

''(B) the measurement under the third sentence of section 1886(d)(3)(E) [42 U.S.C. 1395ww(d)(3)(E)], as amended by paragraph (2).''

PAYMENT FOR INPATIENT SERVICES OF PSYCHIATRIC HOSPITALS

Pub. L. 106–554, §1(a)(6) [title III, §306], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: ''With respect to hospitals described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section, in making incentive payments to such hospitals under section 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the Secretary of Health and Human Services, in clause (ii) of such section, shall substitute '3 percent' for '2 percent'.''

EXPEDITING RECOGNITION OF NEW TECHNOLOGIES INTO INPATIENT PPS CODING SYSTEM

Pub. L. 106–554, §1(a)(6) [title V, §533(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–548, provided that:

''(1) REPORT.—Not later than April 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report on methods of expeditiously incorporating new medical services and technologies into the clinical coding system used with respect to payment for inpatient hospital services furnished under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], together with a detailed description of the Secretary's preferred methods to achieve this purpose.

''(2) IMPLEMENTATION.—Not later than October 1, 2001, the Secretary shall implement the preferred methods described in the report transmitted pursuant to paragraph (1).''

CONSULTATION PRIOR TO RULEMAKING

Pub. L. 106–554, §1(a)(6) [title V, §533(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–549, provided that: ''The Secretary of Health and Human Services shall consult with groups representing hospitals, physicians, and manufacturers of new medical technologies before publishing the notice of proposed rulemaking required by section 1886(d)(5)(K)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(K)(i)] (as added by paragraph (1)).''

SPECIAL PAYMENTS TO MAINTAIN 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2000

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §111(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–329, provided that:

''(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if 'c' in clause (ii)(IV) of such section equalled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

''(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d)).''

DATA COLLECTION

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §112(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–330, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-medicare bad debt, charity care, and charges for medicaid and indigent care.

''(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after October 1, 2001.''

PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS

Pub. L. 106–554, §1(a)(6) [title III, §307(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: ''The amendments made by subsection (a) [amending this section] and by section 122 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §122], amending this section] (113 Stat. 1501A–331) shall not be taken into account in the development and implementation of the prospective payment system under section 123 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §123], set out as a note below] (113 Stat. 1501A–331).''

Pub. L. 106–554, §1(a)(6) [title III, §307(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that:

''(1) MODIFICATION OF REQUIREMENT.—In developing the prospective payment system for payment for inpatient hospital services provided in long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.] required under section 123 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §123], set out as a note below], the Secretary of Health and Human Services shall examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data. The Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

''(2) DEFAULT IMPLEMENTATION OF SYSTEM BASED ON EXISTING DRG METHODOLOGY.—If the Secretary is unable to implement the prospective payment system under section 123 of the BBRA by October 1, 2002, the Secretary shall implement a prospective payment system for such hospitals that bases payment under such a system using existing hospital diagnosis-related groups (DRGs), modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for such services furnished on or after that date.''

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §123], Nov. 29, 1999, 113 Stat. 1536, 1501A–331, provided that:

''(a) DEVELOPMENT OF SYSTEM.—

''(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

''(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

''(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

''(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).''

PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §124], Nov. 29, 1999, 113 Stat. 1536, 1501A–332, provided that:

''(a) DEVELOPMENT OF SYSTEM.—

''(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

''(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

''(3) DEFINITION.—In this section, the term 'psychiatric hospitals and units' means a psychiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

''(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

''(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.''

STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §125(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)).

''(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.''

MEDPAC STUDY ON MEDICARE PAYMENT FOR NONPHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §141], Nov. 29, 1999, 113 Stat. 1536, 1501A–334, provided that:

''(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment policy with respect to professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Com-

mission shall submit a report to Congress on the study conducted under subsection (a).''

NOT COUNTING AGAINST NUMERICAL LIMITATION CERTAIN INTERNS AND RESIDENTS TRANSFERRED FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDITATION

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §407(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that:

''(1) IN GENERAL.—Any applicable resident described in paragraph (2) shall not be taken into account in applying any limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

''(2) APPLICABLE RESIDENT DESCRIBED.—An applicable resident described in this paragraph is a resident or intern who—

''(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

''(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital that was not a Department of Veterans Affairs facility; and

''(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

''(3) EFFECTIVE DATE.—

''(A) IN GENERAL.—Paragraph (1) applies as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

''(B) RETROACTIVE PAYMENTS.—If the Secretary of Health and Human Services determines that a hospital operating an approved medical residency program is owed payments as a result of enactment of this subsection, the Secretary shall make such payments not later than 60 days after the date of the enactment of this Act [Nov. 29, 1999].''

GAO STUDY ON GEOGRAPHIC RECLASSIFICATION

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §410], Nov. 29, 1999, 113 Stat. 1536, 1501A–376, provided that:

''(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices under the medicare program and whether such reclassification results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their reclassified status in determining payments under the medicare program. The study shall evaluate—

''(1) the magnitude of the effect of geographic reclassification on rural hospitals that are not reclassified;

''(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

''(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

''(4) the group reclassification policy;

''(5) changes in the number of reclassifications and the compositions of the groups;

''(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

''(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).''

CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS

Pub. L. 105–33, title IV, §4202(b), Aug. 5, 1997, 111 Stat. 375, provided that:

''(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

''(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(8)(D)] shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act [42 U.S.C. 1395ww(d)(10)].''

HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS

Pub. L. 105–33, title IV, §4203, Aug. 5, 1997, 111 Stat. 375, provided that:

''(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)(i)) of a hospital described in 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)) to change the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)).

''(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification by reason of subsection (a) until the Secretary of Health and Human Services promulgates separate guidelines for such reclassification.

''(c) PERIOD DESCRIBED.—The period described in this subsection is the period beginning on the date of the enactment of this Act [Aug. 5, 1997] and ending 30 months after such date.''

TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS

Pub. L. 105–33, title IV, §4401(b), Aug. 5, 1997, 111 Stat. 397, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366, provided that:

''(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

''(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1998 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.5 percentage points; and

''(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV))) had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B) and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement after the close of the fiscal year.

''(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

''(A) that is described in paragraph (3) for such period;

''(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of

such Act [42 U.S.C. 1395ww(d)] for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1995 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting periods; and

''(C) with respect to which the payments under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4))[)] for such hospital for such period, as estimated by the Secretary.

''(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) that—

''(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) for discharges occurring during the period;

''(B) is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period; and

''(C) does not qualify for payment under section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) for the period.''

FORMULA FOR ADDITIONAL PAYMENT AMOUNTS; REPORT

Pub. L. 105–33, title IV, §4403(b), (c), Aug. 5, 1997, 111 Stat. 399, provided that:

''(b) REPORT ON NEW PAYMENT FORMULA.—

''(1) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that contains a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

''(2) FACTORS IN DETERMINATION OF FORMULA.—In determining such formula the Secretary shall—

''(A) establish a single threshold for costs incurred by hospitals in serving low-income patients, and

''(B) consider the costs described in paragraph (3).

''(3) The costs described in this paragraph are as follows:

''(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] and who receive supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] (excluding any supplementation of those benefits by a State under section 1616 of such Act (42 U.S.C. 1382e)).

''(B) The costs incurred by the hospital during a period (as so determined) of furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] and are not entitled to benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] (including individuals enrolled in a managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A)) or any other managed care plan under such title and individuals who receive medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115 of such Act (42 U.S.C. 1315)).

''(c) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula.''

GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS

Pub. L. 105–33, title IV, §4409, Aug. 5, 1997, 111 Stat. 402, provided that:

''(a) NEW GUIDELINES FOR RECLASSIFICATION.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

''(b) HOSPITALS COVERED.—A hospital described in this subsection is a hospital that demonstrates that—

''(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

''(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area is attributable to wages paid by the hospital; and

''(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years.''

FLOOR ON AREA WAGE INDEX

Pub. L. 105–33, title IV, §4410, Aug. 5, 1997, 111 Stat. 402, provided that:

''(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))[)] may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

''(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

''(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act [42 U.S.C. 1395ww(d)(10)] for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to

it, shall be reclassified as an urban hospital for fiscal year 1998.''

REPORT ON EFFECT OF AMENDMENTS BY PUB. L. 105–33, § 4415, ON PSYCHIATRIC HOSPITALS

Pub. L. 105–33, title IV, § 4415(d), Aug. 5, 1997, 111 Stat. 407, provided that: ''Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i)) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.)).''

TREATMENT OF CERTAIN CANCER HOSPITALS; PAYMENT

Pub. L. 106–554, § 1(a)(4) [div. B, title I, § 152(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–252, provided that:

''(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(III) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)(v)(III)] (as added by subsection (a)) shall apply to 12-month cost reporting periods beginning on or after July 1, 1999.

''(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(III) of such Act [42 U.S.C. 1395ww(d)(1)(B)(v)(III)] (as added by subsection (a)) shall be the 12-month cost reporting period beginning on July 1, 1995.

''(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Dec. 21, 2000].''

Pub. L. 105–33, title IV, § 4418(b), Aug. 5, 1997, 111 Stat. 409, provided that:

''(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991.

''(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act shall be either—

''(A) the hospital's cost reporting period beginning during fiscal year 1990, or

''(B) pursuant to an election under 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413(b), the period provided for under such section.

''(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Aug. 5, 1997].''

REPORT ON EXCEPTIONS

Pub. L. 105–33, title IV, § 4419(b), Aug. 5, 1997, 111 Stat. 409, provided that: ''The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year.''

DEVELOPMENT OF PROPOSAL ON PAYMENTS FOR LONG-TERM CARE HOSPITALS

Pub. L. 105–33, title IV, § 4422, Aug. 5, 1997, 111 Stat. 414, provided that:

''(a) IN GENERAL.—

''(1) LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop a legislative proposal for establishing a case-mix adjusted prospective payment system for payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

''(2) COLLECTION OF DATA AND EVALUATION.—In developing the legislative proposal described in paragraph (1), the Secretary—

''(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

''(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to apply to payments under the medicare program to long-term care hospitals.

''(b) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of Congress a report that includes the legislative proposal developed under subsection (a)(1).''

DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES

Pub. L. 105–33, title IV, § 4506, Aug. 5, 1997, 111 Stat. 437, provided that:

''(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

''(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

''(A) the hospital-specific per discharge relative value under subsection (b); and

''(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

''(2) NOTICE TO SUBSET OF MEDICAL STAFFS; EVALUATION OF RESPONSES.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

''(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

''(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2))[)] for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

''(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

''(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act [42 U.S.C. 1395w–4(c)(2)]) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and resi-

dents) during the second year preceding that calendar year, and

''(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

''(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)). The adjustment for teaching status or disproportionate share shall not be less than zero.

''(c) DEFINITIONS.—For purposes of this section:

''(1) HOSPITAL.—The term 'hospital' means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

''(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

''(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

''(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

''(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

''(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

''(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

''(3) PHYSICIANS' SERVICES.—The term 'physicians' services' means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)).

''(4) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(6) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).''

INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS; RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY; REGULATIONS

Pub. L. 105–33, title IV, §4626(b), (c), Aug. 5, 1997, 111 Stat. 483, provided that:

''(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

''(1) Section 1886(h)(6) of the Social Security Act [42 U.S.C. 1395ww(h)(6)], added by subsection (a), other than subparagraph (F)(ii) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

''(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

''(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in connection with a reduction in the number of residents in a medical residency training program.

''(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act [Aug. 5, 1997].''

DEMONSTRATION PROJECT ON USE OF CONSORTIA

Pub. L. 105–33, title IV, §4628, Aug. 5, 1997, 111 Stat. 484, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)], the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

''(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

''(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

''(A) A school of allopathic medicine or osteopathic medicine.

''(B) Another teaching hospital, which may be a children's hospital.

''(C) A Federally qualified health center.

''(D) A medical group practice.

''(E) A managed care entity.

''(F) An entity furnishing outpatient services.

''(G) Such other entity as the Secretary determines to be appropriate.

''(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

''(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

''(4) The consortium meets such additional requirements as the Secretary may establish.

''(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) or (k) of the Social Security Act [42 U.S.C. 1395ww(h), (k)] for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act [42 U.S.C. 1395 et seq.] as the Secretary specifies.''

RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Pub. L. 105–33, title IV, §4629, Aug. 5, 1997, 111 Stat. 484, provided that:

''(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act [42 U.S.C. 1395b–6] and in this section referred to as the 'Commission') shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies

regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

''(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

''(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

''(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

''(2) Federal policies regarding international medical graduates.

''(3) The dependence of schools of medicine on service-generated income.

''(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

''(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

''(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

''(1) deans from allopathic and osteopathic schools of medicine;

''(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

''(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

''(4) individuals with leadership experience from representative fields of non-physician health professionals;

''(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

''(6) individuals with expertise in health care payment policies.

''(c) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.''

STUDY OF HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS

Pub. L. 105–33, title IV, §4630, Aug. 5, 1997, 111 Stat. 485, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

''(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)], and

''(2) the reasons for such variations.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate.''

DRG PROSPECTIVE PAYMENT RATE METHODOLOGY; TRANSITION RULE FOR FISCAL YEAR 1998

Pub. L. 105–33, title IV, §4644(a)(2), Aug. 5, 1997, 111 Stat. 488, provided that: ''With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term '60 days' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to '30 days'.''

HOSPITAL PAYMENT UPDATES; TRANSITION RULE FOR FISCAL YEAR 1998

Pub. L. 105–33, title IV, §4644(b)(2), Aug. 5, 1997, 111 Stat. 488, provided that: ''With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term '60 days' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to '30 days'.''

GEOGRAPHICAL RECLASSIFICATION; SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997

Pub. L. 105–33, title IV, §4644(c)(2), Aug. 5, 1997, 111 Stat. 488, provided that: ''In the case of an application for a change in geographic classification under such section [42 U.S.C. 1395ww(d)(10)(C)(ii)] for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines under such section so as to permit completion of a final decision by the Secretary by June 15, 1998.''

NO STANDARDIZED AMOUNT ADJUSTMENTS FOR FISCAL YEARS 1992 OR 1993

Pub. L. 103–66, title XIII, §13501(b)(2), Aug. 10, 1993, 107 Stat. 574, provided that: ''The Secretary of Health and Human Services shall not revise the fiscal year 1992 or fiscal year 1993 standardized amounts pursuant to subsections (d)(3)(B) and (d)(8)(D) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(d)(3)(B), (d)(8)(D)] to account for the amendment made by paragraph (1) [amending this section].''

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATIONS THROUGH FISCAL YEAR 1994; RECLASSIFICATION

Pub. L. 103–66, title XIII, §13501(d), Aug. 10, 1993, 107 Stat. 575, provided that:

''(1) EXTENSION OF CLASSIFICATION THROUGH FISCAL YEAR 1994.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] as of September 30, 1992, shall continue to be so classified for cost reporting periods beginning during fiscal year 1993 or fiscal year 1994, unless the area in which the hospital is located is redesignated as a Metropolitan Statistical Area by the Office of Management and Budget for such a fiscal year.

''(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a rural referral center under section 1886(d)(5)(C) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993 or fiscal year 1994, the Secretary of Health and Human Services shall—

''(A) notify such hospital of such failure to qualify,

''(B) provide an opportunity for such hospital to decline such reclassification, and

''(C) if the hospital—

''(i) declines such reclassification, administer the Social Security Act [42 U.S.C. 301 et seq.] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred, or

''(ii) fails to decline such reclassification, administer the Social Security Act without regard to paragraph (1).

''(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT FOR HOSPITALS LOSING CLASSIFICATION.—

''(A) IN GENERAL.—In the case of a hospital described in paragraph (1), the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, the hospital was classified a regional referral center under section 1886(d)(5)(C) of such Act.

''(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the 'period of applicability' is the period that begins on October 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993].''

HOSPITALS DECLINING URBAN AREA RECLASSIFICATIONS; RETROACTIVE PAYMENTS

Pub. L. 103–66, title XIII, §13501(e)(2), (3), Aug. 10, 1993, 107 Stat. 576, as amended by Pub. L. 105–33, title IV, §4204(a)(3), Aug. 5, 1997, 111 Stat. 376; Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §404(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–372; Pub. L. 109–171, title V, §5003(a)(2)(B), Feb. 8, 2006, 120 Stat. 32; Pub. L. 111–148, title III, §3124(b)(2), Mar. 23, 2010, 124 Stat. 425; Pub. L. 112–240, title VI, §606(b)(2), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §1106(b)(2), Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, §106(b)(2), Apr. 1, 2014, 128 Stat. 1042; Pub. L. 114–10, title II, §205(b)(2), Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E, title II, §50205(b)(2), Feb. 9, 2018, 132 Stat. 183, provided that:

''(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(G)(i)] as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993, fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000 through fiscal year 2022, the Secretary of Health and Human Services shall—

''(A) notify such hospital of such failure to qualify,

''(B) provide an opportunity for such hospital to decline such reclassification, and

''(C) if the hospital declines such reclassification, administer the Social Security Act [42 U.S.C. 301 et seq.] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred.

''(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT.—

''(A) IN GENERAL.—In the case of a hospital treated as a medicare-dependent, small rural hospital under section 1886(d)(5)(G) of the Social Security Act, the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, section 1886(d)(5)(G) of such Act had been applied as if the amendments made by paragraph (1) [amending this section] had been in effect.

''(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the 'period of applicability' is, with respect to a hospital, the period that begins on the first day of the hospital's first 12-month cost reporting period that begins after April 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993].''

ADJUSTMENT IN GME BASE-YEAR COSTS OF FEDERAL INSURANCE CONTRIBUTIONS ACT

Pub. L. 103–66, title XIII, §13563(d), Aug. 10, 1993, 107 Stat. 606, provided that:

''(1) IN GENERAL.—In determining the amount of payment to be made under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] in the case of a hospital described in paragraph (2) for cost reporting periods beginning on or after October 1, 1992, the Secretary of Health and Human Services shall redetermine the approved FTE resident amount to reflect the amount that would have been paid the hospital if, during the hospital's base cost reporting period, the hospital had been liable for FICA taxes or for contributions to the retirement system of a State, a political subdivision of a State, or an instrumentality of such a State or political subdivision with respect to interns and residents in its medical residency training program.

''(2) HOSPITALS AFFECTED.—A hospital described in this paragraph is a hospital that did not pay FICA taxes with respect to interns and residents in its medical residency training program during the hospital's base cost reporting period, but is required to pay FICA taxes or make contributions to a retirement system described in paragraph (1) with respect to such interns and residents because of the amendments made by section 11332(b) of OBRA–1990 [Pub. L. 101–508, amending section 3121 of Title 26, Internal Revenue Code].

''(3) DEFINITIONS.—In this subsection:

''(A) The 'base cost reporting period' for a hospital is the hospital's cost reporting period that began during fiscal year 1984.

''(B) The term 'FICA taxes' means, with respect to a hospital, the taxes under section 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3111].''

DETERMINATION OF AREA WAGE INDEX FOR DISCHARGES OCCURRING JANUARY 1, 1991 TO OCTOBER 1, 1993

Pub. L. 101–508, title IV, §4002(d)(1), Nov. 5, 1990, 104 Stat. 1388–35, provided that:

''(A) For purposes of section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)] for discharges occurring on or after January 1, 1991, and before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

''(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs.''

STUDY AND REPORT ON RELATIONSHIP BETWEEN NON-WAGE-RELATED INPUT PRICES AND ADJUSTED AVERAGE STANDARDIZED AMOUNTS

Section 4002(e)(2) of Pub. L. 101–508 directed Secretary of Health and Human Services to collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under subsec. (d)(3) of this section to identify extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices, and, not later than June 1, 1993, submit a report to Congress analyzing such data, with such report to include recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

DEADLINE FOR SUBMISSION OF APPLICATIONS TO GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Pub. L. 101–508, title IV, §4002(h)(2)(A), Nov. 5, 1990, 104 Stat. 1388–38, provided that: ''For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act [42 U.S.C. 1395ww(d)(10)] has met the deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section.''

PAYMENTS FOR MEDICAL EDUCATION COSTS

Pub. L. 101–508, title IV, § 4004, Nov. 5, 1990, 104 Stat. 1388–39, provided that:

''(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [42 U.S.C. 1395ww(h)].

''(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

''(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

''(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

''(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

''(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

''(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

''(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

''(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

''(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

''(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

''(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [42 U.S.C. 1395x(v)]).

''(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

''(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

''(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.''

Pub. L. 101–508, title IV, § 4159, Nov. 5, 1990, 104 Stat. 1388–90, provided that:

''(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [42 U.S.C. 1395ww(h)].

''(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

''(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

''(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

''(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part B of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

''(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

''(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

''(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

''(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

''(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

''(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

''(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [42 U.S.C. 1395x(v)]).

''(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

''(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

''(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.''

DEVELOPMENT OF NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS

Pub. L. 101–508, title IV, §4005(b), Nov. 5, 1990, 104 Stat. 1388–40, provided that:

''(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]) receive payment for the operating and capital-related costs of inpatient hospital services under part A [42 U.S.C. 1395c et seq.] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

''(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

''(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

''(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

''(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

''(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

''(2) REPORTS.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

''(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.''

GUIDANCE TO INTERMEDIARIES AND HOSPITALS

Pub. L. 101–508, title IV, §4005(c)(3), Nov. 5, 1990, 104 Stat. 1388–42, provided that: ''The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act [42 U.S.C. 1395h] and to hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)]) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act.''

FREEZE IN PAYMENTS UNDER PART A OF THIS SUBCHAPTER THROUGH DECEMBER 31, 1990

Pub. L. 101–508, title IV, §4007, Nov. 5, 1990, 104 Stat. 1388–43, provided that:

''(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] (including payments under section 1886 of such Act [42 U.S.C. 1395ww] attributable to or allocated under such part) during the period described in subsection (b):

''(1) The market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period.

''(2) The percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(i)(2)(B) of such Act [42 U.S.C. 1395f(i)(2)(B)] shall be deemed to be 0.

''(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

''(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

''(b) DESCRIPTION OF PERIOD.—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990.''

REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS

Pub. L. 101–508, title IV, §4008(*l*), Nov. 5, 1990, 104 Stat. 1388–53, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)] that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act). Such review shall specifically include standards related to staffing requirements.

''(2) REPORT.—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a).''

PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR

Pub. L. 101–508, title IV, §4207(b)(1), formerly §4027(b)(1), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (5)(C), Oct. 31, 1994, 108 Stat. 4444, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1993, or, if later, the last fiscal year for which there is a maximum deficit amount specified under sec-

tion 601(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 [2 U.S.C. 665(a)(1)]) of more than $50,000,000, except as follows:

''(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

''(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

''(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute.''

PROHIBITION OF PAYMENT CYCLE CHANGES

Pub. L. 101–508, title IV, § 4207(b)(2), formerly § 4027(b)(2), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered by Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act [Nov. 5, 1990], any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up claims processing, or delaying payment of claims, under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

EXTENSION OF AREA WAGE INDEX

Pub. L. 101–403, title I, § 115(a), Oct. 1, 1990, 104 Stat. 870, provided that: ''For purposes of determining the amount of payment made to a hospital under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for the operating costs of inpatient hospital services for discharges occurring on or after October 1, 1990, and on or before October 20, 1990, the Secretary of Health and Human Services, in adjusting such amount under section 1886(d)(3)(E) of such Act [42 U.S.C. 1395ww(d)(3)(E)] to reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage index, shall apply the area wage index applicable to such hospital as of September 30, 1990.''

ADJUSTMENTS RESULTING FROM EXTENSIONS OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS

Pub. L. 101–403, title I, § 115(b)(2), Oct. 1, 1990, 104 Stat. 870, provided that: ''The Secretary of Health and Human Services shall make any adjustments resulting from the amendment made by paragraph (1) [amending this section] in the amount of the payments made to hospitals under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] in a fiscal year for the operating costs of inpatient hospital services in a manner that ensures that the aggregate payments under such section are not greater or less than those that would have been made in the year without such adjustments.''

INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES

Pub. L. 101–239, title VI, § 6003(a)(3), Dec. 19, 1989, 103 Stat. 2140, provided that: ''For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as amended by paragraph (1).''

CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS

Pub. L. 101–239, title VI, § 6003(e)(3), Dec. 19, 1989, 103 Stat. 2144, provided that: ''Any hospital classified as a sole community hospital under section 1886(d)(5)(C)(ii) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(ii)] on the date of the enactment of this Act [Dec. 19, 1989] that will no longer be classified as a sole community hospital after such date as a result of the amendments made by paragraph (1) [amending this section] shall continue to be classified as a sole community hospital for purposes of section 1886(d)(5)(D) of such Act [42 U.S.C. 1395ww(d)(5)(D)].''

ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX

Pub. L. 101–239, title VI, § 6003(h)(5), Dec. 19, 1989, 103 Stat. 2157, provided that:

''(A) IN GENERAL.—If the Secretary of Health and Human Services (hereinafter referred to as the 'Secretary') discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)] and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act [42 U.S.C. 1395 et seq.] to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.

''(B) CONDITIONS FOR ADDITIONAL PAYMENT.—A hospital is eligible for an additional payment under subparagraph (A) only if—

''(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

''(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and

''(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

''(C) PERIOD OF APPLICABILITY.—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990.''

LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS

Pub. L. 101–239, title VI, § 6003(i), Dec. 19, 1989, 103 Stat. 2158, directed Secretary of Health and Human Services to design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals classified as being located in large urban, other urban, or rural areas, prior to repeal by Pub. L. 105–362, title VI, § 601(b)(4), Nov. 10, 1998, 112 Stat. 3286.

DETERMINATION AND RECOMMENDATIONS OF PAYMENTS FOR COSTS OF ADMINISTERING BLOOD CLOTTING FACTORS TO INDIVIDUALS WITH HEMOPHILIA

Pub. L. 101–239, title VI, § 6011(b), (c), Dec. 19, 1989, 103 Stat. 2161, provided that:

''(b) DETERMINING PAYMENT AMOUNT.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

''(c) RECOMMENDATIONS ON PAYMENTS.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act [Dec. 19, 1989].''

PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS

Pub. L. 101–239, title VI, § 6015(b), Dec. 19, 1989, 103 Stat. 2164, provided that: ''By not later than 180 days after the date of enactment of this Act [Dec. 19, 1989],

the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act [42 U.S.C. 1395ww(b)(4)(A)].''

DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS

Pub. L. 101–239, title VI, §6205(b), Dec. 19, 1989, 103 Stat. 2243, provided that:

''(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of 'operating costs of inpatient hospital services' pursuant to section 1886(a)(4) of such Act [42 U.S.C. 1395ww(a)(4)], so that no pass-through of such costs was permitted under that section.

''(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

''(B) In issuing such regulations—

''(i) the Secretary shall allow a comment period of not less than 60 days,

''(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

''(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

''(C) Such regulations shall specify—

''(i) the relationship required between an approved nursing or allied health education program and a hospital for the program's costs to be attributed to the hospital;

''(ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;

''(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act [42 U.S.C. 1395ww(a)(3)] and educational costs treated as operating costs of inpatient hospital services; and

''(iv) the treatment of other funding sources for the program.''

INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT

Pub. L. 101–239, title VI, §6217, Dec. 19, 1989, 103 Stat. 2253, as amended by Pub. L. 101–508, title IV, §4207(k)(5), formerly §4027(k)(5), Nov. 5, 1990, 104 Stat. 1388–125, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that:

''(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year) for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

''(1) to train hospital personnel to operate and participate in the system; and

''(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

''(b) LIMITATIONS ON PAYMENT.—(1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

''(2) The amount of payment made under the demonstration project during a single year may not exceed $500,000.''

TRANSITION ADJUSTMENTS TO TARGET AMOUNTS FOR INPATIENT HOSPITAL SERVICES

Pub. L. 101–234, title I, §101(c)(2)(B), Dec. 13, 1989, 103 Stat. 1980, provided that: ''The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(A)] in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title [see Tables for classification].''

ELECTION OF PERSONNEL POLICY FOR PROPAC EMPLOYEES

Pub. L. 100–647, title VIII, §8405, Nov. 10, 1988, 102 Stat. 3800, provided that: ''With respect to employees of the Prospective Payment Assessment Commission hired before December 22, 1987, such employees shall have the option to elect within 60 days of the date of enactment of this Act [Nov. 10, 1988] to be covered under either the personnel policy in effect with respect to such employees before December 22, 1987, or under the employees coverage provided under the last sentence of section 1886(e)(6)(D) of the Social Security Act [42 U.S.C. 1395ww(e)(6)(D)].''

ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES

Pub. L. 100–360, title I, §104(c), July 1, 1988, 102 Stat. 688, as amended by Pub. L. 100–485, title VI, §608(d)(3)(C)–(E), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101–234, title I, §101(c)(1), (2)(A), Dec. 13, 1989, 103 Stat. 1980, provided that:

''(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, and before January 1, 1990, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]).

''(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act [42 U.S.C. 1395ww(b)(3)] for portions of cost reporting periods occurring on or after January 1, 1989, and before January 1, 1990, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]), without regard to whether such a hospital is paid on the basis described in subparagraph (A) or (B) of section 1886(b)(1) of such Act, without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.''

[Amendment of section 104(c) of Pub. L. 100–360, set out above, by section 101(c)(1), (2)(A) of Pub. L. 101–234 effective as if included in enactment of Pub. L. 100–360, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title].

PROPAC STUDY

Pub. L. 100–360, title II, §203(c)(2), July 1, 1988, 102 Stat. 723, directed Prospective Payment Assessment Commission to conduct a study, and make recommendations to Congress and Secretary of Health and Human Services by not later than Mar. 1, 1991, concerning appropriate adjustment to payment amounts provided under subsec. (d) of this section for inpatient hospital services to account for reduced costs to hos-

pitals resulting from amendments made by section 203 of Pub. L. 100–360, amending sections 1320c–3, 1395h, 1395k to 1395n, 1395w–2, 1395x, 1395z, and 1395aa of this title, prior to repeal by Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

CLINIC HOSPITAL WAGE INDICES

Pub. L. 100–203, title IV, § 4004(b), Dec. 22, 1987, 101 Stat. 1330–47, provided that: ''In calculating the wage index under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for purposes of making payment adjustments after September 30, 1988, as required under paragraphs (2)(H) and (3)(E) of such section, in the case of any institution which received the waiver specified in section 602(k) of the Social Security Amendments of 1983 [section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title], the Secretary of Health and Human Services shall include wage costs paid to related organization employees directly involved in the delivery and administration of care provided by the related organization to hospital inpatients. For purposes of the preceding sentence, the term 'wage costs' does not include costs of overhead or home office administrative salaries or any costs that are not incurred in the hospital's Metropolitan Statistical Area.''

LIMITATION ON AMOUNTS PAID IN FISCAL YEARS 1988 AND 1989

Pub. L. 100–203, title IV, § 4005(c)(2)(B), Dec. 22, 1987, 101 Stat. 1330–49, provided that: ''The Secretary of Health and Human Services shall take appropriate steps to ensure that the total amount paid in a fiscal year under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] by reason of the amendment made by paragraph (1)(B) [amending this section] does not exceed $5,000,000 in the case of fiscal year 1988 and $10,000,000 for fiscal year 1989.''

STUDY OF CRITERIA FOR CLASSIFICATION OF HOSPITALS AS RURAL REFERRAL CENTERS; REPORT

Pub. L. 100–203, title IV, § 4005(d)(2), Dec. 22, 1987, 101 Stat. 1330–49, directed Secretary of Health and Human Services to provide for a study of the criteria used for the classification of hospitals as rural referral centers, and report to Congress, by not later than Mar. 1, 1989, on the study and on recommendations for the criteria that should be applied for the classification of hospitals as rural referral centers for cost reporting periods beginning on or after Oct. 1, 1989.

GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION

Pub. L. 100–203, title IV, § 4005(e), Dec. 22, 1987, 101 Stat. 1330–50, as amended by Pub. L. 101–239, title VI, § 6003(g)(1)(B)(i), Dec. 19, 1989, 103 Stat. 2150; Pub. L. 103–432, title I, § 103(a)(1), (b), (c), Oct. 31, 1994, 108 Stat. 4404, 4405, provided that:

''(1) The Administrator of the Health Care Financing Administration, in consultation with the Assistant Secretary for Health (or a designee), shall establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

''(A) Changes in clinical practice patterns.

''(B) Changes in service populations.

''(C) Declining demand for acute-care inpatient hospital capacity.

''(D) Declining ability to provide appropriate staffing for inpatient hospitals.

''(E) Increasing demand for ambulatory and emergency services.

''(F) Increasing demand for appropriate integration of community health services.

''(G) The need for adequate access (including appropriate transportation) to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

''(H) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

Each demonstration project under this subsection shall demonstrate methods of strengthening the financial and managerial capability of the hospital involved to provide necessary services. Such methods may include programs of cooperation with other health care providers, of diversification in services furnished (including the provision of home health services), of physician recruitment, and of improved management systems. Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act [42 U.S.C. 254e(a)(1)(A)].

''(2) For purposes of this subsection, the term 'eligible small rural hospital' means any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act [42 U.S.C. 1395i–4(i)(2)], or any non-Federal, short-term general acute care hospital that—

''(A) is located in a rural area (as determined in accordance with subsection (d)),

''(B) has less than 100 beds, and

''(C) is not for profit.

''(3)(A) Any eligible small rural hospital that desires to modify the type or extent of health care services that it provides in order to adjust for one or more of the factors specified in paragraph (1) may submit an application to the Administrator and a copy of such application to the Governor of the State in which it is located. The application shall specify the nature of the project proposed by the hospital, the data and information on which the project is based, and a timetable (of not more than 24 months) for completion of the project. The application shall be submitted on or before a date specified by the Administrator and shall be in such form as the Administrator may require.

''(B) The Governor shall transmit to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A), any comments with respect to the application that the Governor deems appropriate.

''(C) The Governor of a State may designate an appropriate State agency to receive and comment on applications submitted under subparagraph (A).

''(4) A hospital shall be considered to be located in a rural area for purposes of this subsection if it is treated as being located in a rural area for purposes of section 1886(d)(3)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(D)].

''(5) In determining which hospitals making application under paragraph (3) will receive grants under this subsection, the Administrator shall take into account—

''(A) any comments received under paragraph (3)(B) with respect to a proposed project;

''(B) the effect that the project will have on—

''(i) reducing expenditures from the Federal Hospital Insurance Trust Fund,

''(ii) improving the access of medicare beneficiaries to health care of a reasonable quality;

''(C) the extent to which the proposal of the hospital, using appropriate data, demonstrates an understanding of—

''(i) the primary market or service area of the hospital, and

''(ii) the health care needs of the elderly and disabled that are not currently being met by providers in such market or area, and

''(D) the degree of coordination that may be expected between the proposed project and—

''(i) other local or regional health care providers, and

''(ii) community and government leaders,

as evidenced by the availability of support for the project (in cash or in kind) and other relevant factors.

''(6) A grant to a hospital under this subsection may not exceed $50,000 a year and may not exceed a term of 3 years.

''(7)(A) Except as provided in subparagraphs (B) and (C), a hospital receiving a grant under this subsection may use the grant for any of expenses incurred in planning and implementing the project with respect to which the grant is made.

''(B) A hospital receiving a grant under this subsection for a project may not use the grant to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

''(C) Not more than one-third of any grant made under this subsection may be expended for capital-related costs (as defined by the Secretary for purposes of section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)]) of the project, except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).

''(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a rural primary care hospital (as described in section 1820 of the Social Security Act [42 U.S.C. 1395i–4]) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).

''(8)(A) A hospital receiving a grant under this section [amending this section and section 1395tt of this title and enacting provisions set out as notes under this section and section 1395tt of this title] shall furnish the Administrator with such information as the Administrator may require to evaluate the project with respect to which the grant is made and to ensure that the grant is expended for the purposes for which it was made.

''(B) The Administrator shall report to the Congress at least once every 12 months on the program of grants established under this subsection. The report shall assess the functioning and status of the program, shall evaluate the progress made toward achieving the purposes of the program, and shall include any recommendations the Secretary may deem appropriate with respect to the program. In preparing the report, the Secretary shall solicit and include the comments and recommendations of private and public entities with an interest in rural health care.

''(C) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

''(9) For purposes of carrying out the program of grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $15,000,000 for fiscal year 1989, $25,000,000 for each of the fiscal years 1990, 1991, and 1992 and $30,000,000 for each of fiscal years 1993 through 1997.''

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 6 on page 100 identifies a reporting provision which, as subsequently amended, is contained in section 4005(e)(8)(B) of Pub. L. 100–203, set out above), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

[Pub. L. 103–432, title I, §103(a)(2), Oct. 31, 1994, 108 Stat. 4405, provided that: ''The amendment made by paragraph (1) [amending section 4005(e)(2) of Pub. L. 100–203, set out above] shall apply to grants made on or after October 1, 1994.'']

[Pub. L. 103–432, §103(c), which directed amendment of section 4008(e)(8)(B) of Pub. L. 100–203, was executed by amending section 4005(e)(8)(B) of Pub. L. 100–203, set out above, to reflect the probable intent of Congress.]

[Pub. L. 101–239, title VI, §6003(g)(1)(B)(ii), Dec. 19, 1989, 103 Stat. 2151, provided that: ''The amendments made by clause (i) [amending section 4005(e) of Pub. L. 100–203, set out above] shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203] submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act [Dec. 19, 1989].'']

REPORTING HOSPITAL INFORMATION

Pub. L. 100–203, title IV, §4007, Dec. 22, 1987, 101 Stat. 1330–53, as amended by Pub. L. 100–360, title IV, §411(b)(6), July 1, 1988, 102 Stat. 770; Pub. L. 100–485, title VI, §608(d)(18)(D), Oct. 13, 1988, 102 Stat. 2419, provided that:

''(a) DEVELOPMENT OF DATA BASE.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall develop and place into effect not later than June 1, 1989, a data base of the operating costs of inpatient hospital services with respect to all hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], which data base shall be updated at least once every quarter (and maintained for the 12-month period preceding any such update). The data base under this subsection may include data from preliminary cost reports (but the Secretary shall make available an updated analysis of the differences between preliminary and settled cost reports).

''(b) [Amended subsec. (f) of this section and enacted provisions set out as an Effective Date of 1987 Amendment note above.]

''(c) DEMONSTRATION PROJECT.—

''(1) The Secretary of Health and Human Services shall provide for a demonstration project to develop, and determine the costs and benefits of establishing a uniform system for the reporting by medicare participating hospitals of balance sheet and information described in paragraph (2). In conducting the project, the Secretary shall require hospitals in at least 2 States, one of which maintains a uniform hospital reporting system, to report such information based on standard information established by the Secretary.

''(2) The information described in this paragraph is as follows:

''(A) Hospital discharges (classified by class of primary payer).

''(B) Patient days (classified by class of primary payer).

''(C) Licensed beds, staffed beds, and occupancy.

''(D) Inpatient charges and revenues (classified by class of primary payer).

''(E) Outpatient charges and revenues (classified by class of primary payer).

''(F) Inpatient and outpatient hospital expenses (by cost-center classified for operating and capital).

''(G) Reasonable costs.

''(H) Other income.

''(I) Bad debt and charity care.

''(J) Capital acquisitions.

''(K) Capital assets.

The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.

''(3) The Secretary shall develop the system under subsection (c) in a manner so as—

''(A) to facilitate the submittal of the information in the report in an electronic form, and

''(B) to be compatible with the needs of the medicare prospective payment system.

''(4) The Secretary shall prepare and submit, to the Prospective Payment Assessment Commission, the Comptroller General, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, by not later than 45 days after the end of each calendar quarter, data collected under the system.

''(5) In paragraph (2):

''(A) The term 'bad debt and charity care' has such meaning as the Secretary establishes.

''(B) The term 'class' means, with respect to payers at least, the programs under this title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], other third party-payers, and other persons (including self-paying individuals).

''(6) The Secretary shall set aside at least a total of $3,000,000 for fiscal years 1988, 1989, and 1990 from existing research funds or from operations funds to develop the format, according to paragraph (1) and for data collection and analysis, but total funds shall not exceed $15,000,000.

''(7) The Comptroller General shall analyze the adequacy of the existing system for reporting of hospital information and the costs and benefits of data reporting under the demonstration system and will recommend improvements in hospital data collection and in analysis and display of data in support of policy making.

''(d) CONSULTATION.—The Secretary shall consult representatives of the hospital industry in carrying out the provisions of this section.''

HOSPITAL OUTLIER PAYMENTS AND POLICY

Pub. L. 100–203, title IV, § 4008(d), Dec. 22, 1987, 101 Stat. 1330–55, as amended by Pub. L. 100–360, title IV, § 411(b)(7), July 1, 1988, 102 Stat. 771, provided that:

''(1) INCREASE IN OUTLIER PAYMENTS FOR BURN CENTER DRGS.—

''(A) IN GENERAL.—For discharges classified in diagnosis-related groups relating to burn cases and occurring on or after April 1, 1988, and before October 1, 1989, the marginal cost of care permitted by the Secretary of Health and Human Services under section 1886(d)(5)(A)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(A)(iii)] shall be 90 percent of the appropriate per diem cost of care or 90 percent of the cost for cost outliers.

''(B) BUDGET NEUTRALITY.—Subparagraph (A) shall be implemented in a manner that ensures that total payments under section 1886(d) of the Social Security Act are not increased or decreased by reason of the adjustments required by such subparagraph.

''(2) LIMITATION ON CHANGES IN OUTLIER REGULATIONS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before September 1, 1988, any final regulation which changes the method of payment for outlier cases under section 1886(d)(5)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(A)].

''(B) PROPAC REPORT.—The chairman of the Prospective Payment Assessment Commission shall report to the Congress and the Secretary of Health and Human Services, by not later than June 1, 1988, on the method of payment for outlier cases under such section and providing more adequate and appropriate payments with respect to burn outlier cases.

''(3) REPORT ON OUTLIER PAYMENTS.—The Secretary of Health and Human Services shall include in the annual report submitted to the Congress pursuant to section 1875(b) of the Social Security Act [42 U.S.C. 1395*ll*(b)] a comparison with respect to hospitals located in an urban area and hospitals located in a rural area in the amount of reductions under section 1886(d)(3)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(B)] and additional payments under section 1886(d)(5)(A) of such Act.''

PROPAC STUDIES AND REPORTS

Pub. L. 100–203, title IV, § 4009(h), Dec. 22, 1987, 101 Stat. 1330–58, provided that:

''(1) PROPAC REPORTS ON STUDY OF DRG RATES FOR HOSPITALS IN RURAL AND URBAN AREAS.—The Prospective Payment Assessment Commission shall evaluate the study conducted by the Secretary of Health and Human Services pursuant to section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 [section 603(a)(2)(C)(i) of Pub. L. 98–21, set out below] (relating to the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates) and report its conclusions and recommendations to the Congress not later than March 1, 1988.

''(2) PROPAC REPORT ON SEPARATE URBAN PAYMENT RATES.—The Prospective Payment Assessment Commission shall evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas (as defined in section 1886(d)(2)(D)) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) and in other urban areas, and shall report to Congress on such evaluation not later than January 1, 1989.

''(3) REPORT ON ADJUSTMENT FOR NON-LABOR COSTS.—The Prospective Payment Assessment Commission shall perform an analysis to determine the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts under section 1886(d)(3) of the Social Security Act [42 U.S.C. 1395ww(d)(3)] based on area differences in hospitals' costs (other than wage-related costs) and input prices. The Commission shall report to the Congress on such analysis by not later than October 1, 1989.''

SPECIAL RULE FOR URBAN AREAS IN NEW ENGLAND

Pub. L. 100–203, title IV, § 4009(i), Dec. 22, 1987, 101 Stat. 1330–58, as amended by Pub. L. 100–360, title IV, § 411(b)(8)(C), July 1, 1988, 102 Stat. 772, provided that: ''In the case of urban areas in New England, the Secretary of Health and Human Services shall apply the second sentence of section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)], as amended by section 4002(b) of this subtitle, as though 970,000 were substituted for 1,000,000.''

RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT

Pub. L. 100–203, title IV, § 4038, Dec. 22, 1987, 101 Stat. 1330–80, as amended by Pub. L. 101–239, title VI, § 6216, Dec. 19, 1989, 103 Stat. 2253, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into agreements with 10 sponsoring hospitals submitting applications under this subsection to conduct demonstration projects to assist resident physicians in developing field clinical experience in rural areas.

''(b) NATURE OF PROJECT.—Under a demonstration project conducted under subsection (a), a sponsoring hospital entering into an agreement with the Secretary under such subsection shall enter into arrangements with a small rural hospital to provide to such rural hospital, for a period of one to three months of training, physicians (in such number as the agreement under subsection (a) may provide) who have completed one year of residency training.

''(c) SELECTION.—(1) In selecting from among applications submitted under subsection (a), the Secretary shall ensure that four small rural hospitals located in different counties participate in the demonstration project and that—

''(A) two of such hospitals are located in rural counties of more than 2,700 square miles (one of which is east of the Mississippi River and one of which is west of such river); and

''(B) two of such hospitals are located in rural counties with (as determined by the Secretary) a severe shortage of physicians (one of which is east of the Mississippi River and one of which is west of such river).

''(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 6216 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, amending this note].

''(d) CLARIFICATION OF PAYMENT.—For purposes of section 1886 of the Social Security Act [42 U.S.C. 1395ww]—

''(1) with respect to subsection (d)(5)(B) of such section, any resident physician participating in the project under subsection (a) for any part of a year shall be treated as if he or she were working at the appropriate sponsoring hospital with an agreement under subsection (a) on September 1 of such year (and shall not be treated as if working at the small rural hospital); and

''(2) with respect to subsection (h) of such section, the payment amount permitted under such subsection for a sponsoring hospital with an agreement under subsection (a) shall be increased (for the duration of the project only) by an amount equal to the amount of any direct graduate medical education costs (as defined in paragraph (5) of such subsection (h)) incurred by such hospital in supervising the education and training activities under a project under subsection (a).

''(e) DURATION OF PROJECT.—Each demonstration project under subsection (a) shall be commenced not later than six months after the date of enactment of this Act [Dec. 22, 1987] (or the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 [Dec. 19, 1989], in the case of a project conducted as a result of the amendments made by section 6216 of such Act [Pub. L. 101–239, amending this note]) and shall be conducted for a period of three years.

''(f) DEFINITION.—In this section, the term 'sponsoring hospital' means a hospital that receives payments under sections 1886(d)(5)(B) and 1886(h) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(B), (h)].''

PROHIBITION ON POLICY BY SECRETARY OF HEALTH AND HUMAN SERVICES TO REDUCE EXPENDITURES IN FISCAL YEARS 1989, 1990, AND 1991

Pub. L. 100–203, title IV, §4039(d), Dec. 22, 1987, 101 Stat. 1330–82, as amended by Pub. L. 100–360, title IV, §426(e), July 1, 1988, 102 Stat. 814; Pub. L. 101–239, title VI, §6207(b), Dec. 19, 1989, 103 Stat. 2245, provided that: ''Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before October 15, 1990, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in fiscal year 1989 or in fiscal year 1990 or in fiscal year 1991 of more than $50,000,000.''

TEMPORARY EXTENSION OF PAYMENT POLICIES FOR INPATIENT HOSPITAL SERVICES

Pub. L. 100–119, title I, §107(a)(1), Sept. 29, 1987, 101 Stat. 782, as amended by Pub. L. 100–203, title IV, §4002(f)(2), Dec. 22, 1987, 101 Stat. 1330–45, provided that: ''Notwithstanding any other provision of law, with respect to payment for inpatient hospital services under section 1886 of the Social Security Act [42 U.S.C. 1395ww]:

''(A) TEMPORARY FREEZE IN PPS HOSPITAL RATES.—For purposes of subsection (d) of such section for discharges occurring during the period beginning on October 1, 1987, and ending on November 20, 1987 (in this paragraph referred to as the 'extension period'), the applicable percentage increase under subsection (b)(3)(B) of such section with respect to fiscal year 1988 is deemed to be 0 percent.

''(B) TEMPORARY FREEZE IN PAYMENT BASIS.—

''(i) EXTENSION OF BLENDED DRG RATE.—For purposes of subsection (d)(1) of such section, the 'applicable combined adjusted DRG prospective payment rate' for discharges occurring—

''(I) during the extension period is the rate specified in subsection (d)(1)(D)(ii) of such section, or

''(II) after such period is the national adjusted prospective payment rate determined under subsection (d)(3) of such section.

''(ii) EXTENSION OF HOSPITAL-SPECIFIC PAYMENT.—For the first 51 days of a hospital cost reporting period beginning during fiscal year 1988, payment shall be made under clause (ii) (rather than clause (iii)) of subsection (d)(1)(A) of such section (subject to clause (i) of this subparagraph), the target percentage and DRG percentage shall be those specified in subsection (d)(1)(C)(iv) of such section, and the applicable percentage increase in a hospital's target amount shall be deemed to be 0 percent.

''(C) TEMPORARY FREEZE IN AMOUNTS OF PAYMENT FOR CAPITAL.—For payments attributable to portions of cost reporting periods occurring during the extension period, the percent specified in subsection (g)(3)(A)(ii) of such section is deemed to be 3.5 percent.

''(D) TEMPORARY FREEZE IN RETURN ON EQUITY REDUCTIONS.—For the first 51 days of a cost reporting period beginning during fiscal year 1988, subsection (g)(2) of such section shall be applied as though the applicable percentage were 75 percent.

''(E) TEMPORARY FREEZE IN PAYMENTS RATES FOR PPS-EXEMPT HOSPITALS.—For purposes of payment under subsection (b) of such section for cost reporting periods beginning during fiscal year 1988, with respect to the first 51 days of such a period the applicable percentage increase under paragraph (3)(B) of such subsection is deemed to be 0 percent.''

[Section 4002(f)(2) of Pub. L. 100–203 provided that the amendment of section 107(a)(1) of Pub. L. 100–119, set out above, by section 4002(f)(2) of Pub. L. 100–203 is effective as of Sept. 29, 1987.]

FREEZING CERTAIN CHANGES IN MEDICARE PAYMENT REGULATIONS AND POLICIES

Pub. L. 100–119, title I, §107(b), Sept. 29, 1987, 101 Stat. 783, provided that:

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue after September 18, 1987, and before November 21, 1987—

''(A) any final regulation that changes the policy with respect to payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title;

''(B) any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under such title; or

''(C) any final regulation that changes the policy under such title with respect to payment for a return on equity capital for outpatient hospital services.

The final regulation of the Health Care Financing Administration published on September 1, 1987 (52 Federal Register 32920) and relating to changes to the return on equity capital provisions for outpatient hospital services is void and of no effect.

''(2) OTHER COST SAVINGS POLICIES.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after September 18, 1987, and before November 21, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than $50,000,000. Any regulation, instruction, or policy which is issued in violation of this paragraph is void and of no effect.

''(3) EXCEPTION.—Paragraphs (1) and (2) shall not be construed to apply to any regulation, instruction, or policy required to implement the amendment made by section 9311(a) of the Omnibus Budget Reconciliation Act of 1986 [section 9311(a) of Pub. L. 99–509, which amended section 1395g of this title] (relating to periodic interim payments).''

MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987

Pub. L. 99–509, title IX, §9302(b)(3), Oct. 21, 1986, 100 Stat. 1982, provided that: ''For payments made under

section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for discharges occurring in fiscal year 1987—

''(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

''(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.''

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION

Pub. L. 101–239, title VI, § 6003(d), Dec. 19, 1989, 103 Stat. 2142, provided that: ''Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509, set out below], shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.''

Pub. L. 99–509, title IX, § 9302(d)(2), Oct. 21, 1986, 100 Stat. 1983, provided that: ''Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(i)] on the date of the enactment of this Act [Oct. 21, 1986] shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.''

BUDGET-NEUTRAL IMPLEMENTATION

Pub. L. 99–509, title IX, § 9302(d)(3), Oct. 21, 1986, 100 Stat. 1983, provided that: ''Paragraph (2) [set out as a note above] and the amendment made by paragraph (1)(A) [amending this section] shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act [42 U.S.C. 1395ww] are not increased or decreased by reason of the classifications required by such paragraph or amendment.''

PROMULGATION OF NEW RATE

Pub. L. 99–509, title IX, § 9302(f), Oct. 21, 1986, 100 Stat. 1984, provided that: ''The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act [Oct. 21, 1986], for the publication of the payments rates that will apply under section 1886 of the Social Security Act [42 U.S.C. 1395ww], for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section [amending this section], without regard to the provisions of chapter 5 of title 5, United States Code.''

MISCELLANEOUS ACCOUNTING PROVISION

Pub. L. 99–509, title IX, § 9307(d), Oct. 21, 1986, 100 Stat. 1996, as amended by Pub. L. 100–203, title IV, § 4008(e), Dec. 22, 1987, 101 Stat. 1330–56, provided that: ''Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)], in the case of a hospital that—

''(1) had a cost reporting period beginning on September 28, 29, or 30 of 1985,

''(2) is located in a State in which inpatient hospital services were paid in fiscal year 1985 pursuant to a Statewide demonstration project under section 402 of the Social Security Amendments of 1967 [section 402 of Pub. L. 90–248, enacting section 1395b–1 of this title and amending section 1395*ll* of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92–603, amending sections 1395b–1 and 1395*ll* of this title and enacting provisions set out as a note under section 1395b–1 of this title], and

''(3) elects, by notice to the Secretary of Health and Human Services by not later than April 1, 1988, to have this subsection apply,

during the first 7 months of such cost reporting period the 'target percentage' shall be 75 percent and the 'DRG percentage' shall be 25 percent, and during the remaining 5 months of such period the 'target percentage' and the 'DRG percentage' shall each be 50 percent.''

[Section 4008(e) of Pub. L. 100–203 provided that the amendment of section 9307(d) of Pub. L. 99–509, set out above, by section 4008(e) of Pub. L. 100–203 is effective as if included in the enactment of Pub. L. 99–509.]

TREATMENT OF CAPITAL-RELATED REGULATIONS

Pub. L. 99–509, title IX, § 9321(c), Oct. 21, 1986, 100 Stat. 2016, as amended by Pub. L. 100–119, title I, § 107(a)(2), Sept. 29, 1987, 101 Stat. 783; Pub. L. 100–203, title IV, § 4009(j)(6)(D), (F), Dec. 22, 1987, 101 Stat. 1330–59, provided that:

''(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OPERATING COSTS BEFORE NOVEMBER 21, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before November 21, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.]. Any regulation published in violation of the previous sentence is void and of no effect.

''(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B), (d)(3)(A), (e)(4)] shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

''(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1861(v)(1)(O) and 1886(g)(2) of the Social Security Act [42 U.S.C. 1395x(v)(1)(O), 1395ww(g)(2)] and section 1886(g)(3)(A) and (B) of the Social Security Act [42 U.S.C. 1395ww(g)(3)(A), (B)] (as amended by section 9303(a) of this Act).

''(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term 'capital-related costs' means those capital-related costs that are specifically excluded, under the second sentence of section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)], from the term 'operating costs of inpatient hospital services' (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.''

LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS

Pub. L. 99–509, title IX, § 9321(d), Oct. 21, 1986, 100 Stat. 2017, provided that: ''Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) [set out above] with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act [Oct. 21, 1986] and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in fiscal year 1988 of more than $50,000,000, and which relates to hospitals or physicians.''

STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES; REPORT TO CONGRESS

Pub. L. 99–272, title IX, § 9103(b), Apr. 7, 1986, 100 Stat. 156, provided that:

''(1) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assess-

ment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for purposes of sections 1886(d)(2)(C)(ii), 1886(d)(2)(H), and 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(C)(ii), (H), (3)(E)], in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

''(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1987. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies.''

CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS PARTICIPATING IN REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS

Pub. L. 99–272, title IX, §9108, Apr. 7, 1986, 100 Stat. 161, provided that:

''(a) CONTINUATION OF WAIVERS.—A hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been approved by the Secretary of Health and Human Services pursuant to section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92–603, set out as a note under section 1395b–1 of this title], or under section 402 of the Social Security Amendments of 1967 (as amended by section 222(b) of the Social Security Amendments of 1972) [42 U.S.C. 1395b–1], shall be deemed to meet the requirements of section 1886(c)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(c)(1)(A)] if such system applies—

''(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the geographic area served by such system on January 1, 1985, and

''(2) to the review of at least 75 percent of—

''(A) all revenues or expenses in such geographic area for inpatient hospital services, and

''(B) revenues or expenses in such geographic area for inpatient hospital services provided under the State's plan approved under title XIX [42 U.S.C. 1396 et seq.].

''(b) APPROVAL.—In the case of a hospital cost control system described in subsection (a), the requirements of section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] which apply to States shall instead apply to such system and, for such purposes, any reference to a State is deemed a reference to such system.

''(c) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS

Pub. L. 99–272, title IX, §9114, Apr. 7, 1986, 100 Stat. 163, provided that:

''(a) DISCLOSURE OF INFORMATION.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, the Comptroller General, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act [42 U.S.C. 1395ww] to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

''(b) CONFIDENTIALITY.—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.''

SPECIAL RULES FOR IMPLEMENTATION OF HOSPITAL REIMBURSEMENT

Pub. L. 99–272, title IX, §9115, Apr. 7, 1986, 100 Stat. 163, provided that:

''(a) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this subpart and implementing the amendments made by this subpart [subpart A (§§9101–9115) of part 1 of subtitle A of title IX of Pub. L. 99–272, see Tables for classification].

''(b) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the amendments made by this subpart.''

APPOINTMENT OF ADDITIONAL MEMBERS TO PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Pub. L. 99–272, title IX, §9127(b), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 99–514, title XVIII, §1895(b)(8), Oct. 22, 1986, 100 Stat. 2933, provided that: ''The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a) [amending this section], no later than 60 days after the date of the enactment of this Act [Apr. 7, 1986], for terms of three years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year.''

STUDIES BY SECRETARY; GAO STUDY; REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS; STUDY ON FOREIGN MEDICAL GRADUATES; ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM; PAPERWORK REDUCTION

Pub. L. 99–272, title IX, §9202(c)–(h), Apr. 7, 1986, 100 Stat. 175, as amended by Pub. L. 100–203, title IV, §4085(f), Dec. 22, 1987, 101 Stat. 1330–131; Pub. L. 101–508, title IV, §4118(i)(2), Nov. 5, 1990, 104 Stat. 1388–70, provided that:

''(c) STUDIES BY SECRETARY.—(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. The study shall address—

''(A) the types and numbers of such programs, and number of students supported or trained under each program;

''(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

''(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

The Secretary shall report the results of such study to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives prior to December 31, 1987.

''(2) The Secretary shall conduct a separate study of the advisability of continuing or terminating the exception under section 1886(h)(5)(F)(ii) of the Social Security Act [42 U.S.C. 1395ww(h)(5)(F)(ii)] for geriatric residencies and fellowships, and of expanding such exception to cover other educational activities, particularly those which are necessary to meet the projected health care needs of Medicare beneficiaries. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics. The Secretary shall report the results of such study to the committees described in paragraph (1) prior to July 1, 1990.

''(d) GAO STUDY.—(1) The Comptroller General shall conduct a study of the variation in the amounts of payments made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. Such study shall identify the compo-

nents of such payments (including payments with respect to inpatient hospital services, physicians' services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any variations in the amounts of the payment components between teaching and nonteaching settings and among different teaching settings.

''(2) In carrying out such study, the Comptroller General may utilize a sample of hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings and among teaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians' services under section 2307(c) of the Deficit Reduction Act of 1984 [section 2307(c) of Pub. L. 98–369, set out as a note under section 1395u of this title].

''(3) The Comptroller General shall report the results of the study to the committees described in subsection (c)(1) prior to December 31, 1987.

''(e) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and Human Services shall report to the committees described in subsection (c)(1), not later than December 31, 1987, on whether section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

''(f) STUDY ON FOREIGN MEDICAL GRADUATES.—The Secretary of Health and Human Services shall study, and report to the committees described in subsection (c)(1), not later than December 31, 1987, respecting the use of physicians who are foreign medical graduates (within the meaning of section 1886(h)(5)(D) of the Social Security Act [42 U.S.C. 1395ww(h)(5)(D)]) in the provision of health care services (particularly inpatient and outpatient hospital services) to medicare beneficiaries. Such study shall evaluate—

''(1) the types of services provided;

''(2) the cost of providing such services, relative to the cost of other physicians providing the services or other approaches to providing the services;

''(3) any deficiencies in the quality of the services provided, and methods of assuring the quality of such services; and

''(4) the impact on costs of and access to services if medicare payment for hospitals' costs of graduate medical education of foreign medical graduates were phased out.

''[(g) Repealed. Pub. L. 101–508, title IV, § 4118(i)(2), Nov. 5, 1990, 104 Stat. 1388–70.]

''(h) PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this section and the amendments made by this section [amending this section and section 1395x of this title and enacting notes set out under this section and section 1395x of this title].''

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

Pub. L. 99–272, title IX, § 9202(j), Apr. 7, 1986, 100 Stat. 177, as amended by Pub. L. 99–514, title XVIII, § 1895(b)(10), Oct. 22, 1986, 100 Stat. 2933, provided that: ''In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] or section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1], for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

''(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

''(2) the Secretary may make appropriate adjustments in the regional adjusted DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

''(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act [42 U.S.C. 1395ww(d)] for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data.''

MORATORIUM ON LABORATORY PAYMENT DEMONSTRATIONS; COOPERATION IN STUDY; REPORT TO CONGRESS

Pub. L. 99–272, title IX, § 9204, Apr. 7, 1986, 100 Stat. 177, as amended by Pub. L. 99–509, title IX, § 9339(e), Oct. 21, 1986, 100 Stat. 2037; Pub. L. 100–203, title IV, § 4085(c), Dec. 22, 1987, 101 Stat. 1330–130; Pub. L. 100–647, title VIII, § 8426, Nov. 10, 1988, 102 Stat. 3803, provided that:

''(a) MORATORIUM.—Prior to January 1, 1990, the Secretary of Health and Human Services shall not conduct any demonstration projects relating to competitive bidding as a method of purchasing laboratory services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. The Secretary may contract for the design of, and site selection for, such demonstration projects.

''(b) COOPERATION IN STUDY.—The Secretary of Health and Human Services and the Comptroller General shall assist representatives of clinical laboratories in the industry's conduct of a study to determine whether methods exist which are better than competitive bidding for purposes of utilizing competitive market forces in setting payment levels for laboratory services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. If such a study is conducted by the clinical laboratory industry, the Secretary and the Comptroller General shall comment on such study and submit such comments and the study to the Senate Committee on Finance and the House Committees on Ways and Means and Energy and Commerce.''

MEDICARE HOSPITAL AND PHYSICIAN PAYMENT PROVISIONS; EXTENSION PERIOD

Pub. L. 99–107, § 5, Sept. 30, 1985, 99 Stat. 479, as amended by Pub. L. 99–155, § 2(d), Nov. 14, 1985, 99 Stat. 814; Pub. L. 99–181, § 4, Dec. 13, 1985, 99 Stat. 1172; Pub. L. 99–189, § 4, Dec. 18, 1985, 99 Stat. 1184; Pub. L. 99–201, § 2, Dec. 23, 1985, 99 Stat. 1665; Pub. L. 99–272, title IX, §§ 9101(a), 9301(a), Apr. 7, 1986, 100 Stat. 153, 184, provided that:

''(a) MAINTAINING EXISTING HOSPITAL PAYMENT RATES.—Notwithstanding any other provision of law, the amount of payment under section 1886 of the Social Security Act [42 U.S.C. 1395ww] for inpatient hospital services for discharges occurring (and cost reporting periods beginning) during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services for a discharge occurring on (or the cost reporting period beginning immediately on or before) September 30, 1985.

''(b) MAINTAINING EXISTING PAYMENT RATES FOR PHYSICIANS' SERVICES.—Notwithstanding any other provision of law, the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services which are furnished during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services furnished on September 30, 1985, and the 15-month period, referred to in section 1842(j)(1) of such Act [42 U.S.C. 1395u(j)(1)], shall be deemed to include the extension period.

''(c) EXTENSION PERIOD DEFINED.—

''(1) HOSPITAL PAYMENTS.—For purposes of subsection (a), the term 'extension period' means the period beginning on October 1, 1985, and ending on April 30, 1986.

''(2) PHYSICIAN PAYMENTS.—For purposes of subsection (b), the term 'extension period' means the period beginning on October 1, 1985, and ending on April 30, 1986.''

[Amendment of section 5 of Pub. L. 99–107, set out above, by section 9101(a) of Pub. l. 99–272 effective Mar. 15, 1986, see section 9101(d) of Pub. L. 99–272, set out above.]

DEFINITION OF HOSPITAL SERVING SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS OR PATIENTS ENTITLED TO HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED; IDENTIFICATION

Pub. L. 98–369, div. B, title III, §2315(h), July 18, 1984, 98 Stat. 1080, provided that: ''The Secretary of Health and Human Services shall, prior to December 31, 1984—

''(1) develop and publish a definition of 'hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A' of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for purposes of section 1886(d)(5)(C)(i) of that Act [42 U.S.C. 1395ww(d)(5)(C)(i)], and

''(2) identify those hospitals which meet such definition, and make such identity available to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.''

PROSPECTIVE PAYMENT WAGE INDEX; STUDIES AND REPORTS TO CONGRESS

Pub. L. 98–369, div. B, title III, §2316, July 18, 1984, 98 Stat. 1081, as amended by Pub. L. 99–272, title IX, §9103(a)(1), Apr. 7, 1986, 100 Stat. 156, provided that:

''(a) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section [42 U.S.C. 1395ww(d)(2)(H), (3)(E)], taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act [July 18, 1984], including any changes which the Secretary determines to be necessary to provide for an appropriate index.

''(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring on or after May 1, 1986, to reflect the changes the Secretary has promulgated in final regulations (on September 3, 1985) relating to the hospital wage index under section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)]. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage levels and relative proportions of full-time and part-time workers.

''(c) The Secretary shall conduct a study and report to the Congress on proposed criteria under which, in the case of a hospital that demonstrates to the Secretary in a current fiscal year that the adjustment being made under paragraph (2)(H) or (3)(E) of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(H), (3)(E)] for that hospital's discharges in that fiscal year does not accurately reflect the wage levels in the labor market serving the hospital, the Secretary, to the extent he deems appropriate, would modify such adjustment for that hospital for discharges in the subsequent fiscal year to take into account a difference in payment amounts in that current fiscal year to the hospital that resulted from such inaccuracy.''

[Pub. L. 99–272, title IX, §9103(a)(2), Apr. 7, 1986, 100 Stat. 156, provided that: ''The amendment made by paragraph (1) [amending this note] shall be effective as if it had been included in the Deficit Reduction Act of 1984 [Pub. L. 98–369].'']

DIFFERENT TREATMENT OF CAPITAL-PROJECTS-RELATED COSTS BEFORE AND AFTER IMPLEMENTATION OF SYSTEM FOR INCLUDING SUCH COSTS UNDER PROSPECTIVELY DETERMINED PAYMENT RATE

Pub. L. 98–21, title VI, §601(a)(3), Apr. 20, 1983, 97 Stat. 149, provided that: ''It is the intent of Congress that, in considering the implementation of a system for including capital-related costs under a prospectively determined payment rate for inpatient hospital services, costs related to capital projects for which expenditures are obligated on or after the effective date of the implementation of such a system, may or may not be distinguished and treated differently from costs of projects for which expenditures were obligated before such date.''

NEW ENGLAND HOSPITALS; CLASSIFICATION AS URBAN OR RURAL

Pub. L. 98–21, title VI, §601(g), Apr. 20, 1983, 97 Stat. 163, provided that: ''In determining whether a hospital is in an urban or rural area for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], the Secretary of Health and Human Services shall classify any hospital located in New England as being located in an urban area if such hospital was classified as being located in an urban area under the Standard Metropolitan Statistical Area system of classification in effect in 1979.''

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS RELATED TO INCLUSION IN PROSPECTIVE PAYMENT AMOUNTS OF INPATIENT HOSPITAL SERVICE CAPITAL-RELATED COSTS

Pub. L. 98–21, title VI, §603(a), Apr. 20, 1983, 97 Stat. 166, as amended by Pub. L. 98–369, div. B, title III, §2317, July 18, 1984, 98 Stat. 1081; Pub. L. 99–509, title IX, §9305(i)(1), Oct. 21, 1986, 100 Stat. 1993; Pub. L. 104–66, title I, §1061(d), Dec. 21, 1995, 109 Stat. 720, directed Secretary of Health and Human Services to report to Congress within 18 months after Apr. 20, 1983, on legislation by which capital-related costs associated with inpatient hospital services could be included within the prospective payment amounts computed under subsec. (d) of this section, further provided that the Secretary was to study and report to Congress on reimbursement of sole community hospitals based on variations in occupancy, on coordination of an information transfer between parts A and B of this subchapter, on treatment of uncompensated care costs and adjustments appropriate for large rural teaching hospitals, and on advisability of having hospitals make cost-of-care information to certain patients, and further provided that the Secretary was to study and report to Congress on a method for including hospitals outside the 50 States and the District of Columbia under a prospective payment system.

INAPPLICABILITY OF COORDINATION OF FEDERAL INFORMATION POLICY TO THE COLLECTION OF INFORMATION

Pub. L. 97–248, title I, §101(b)(2)(B), Sept. 3, 1982, 96 Stat. 335, as amended by Pub. L. 97–448, title III, §309(a)(1), Jan. 12, 1983, 96 Stat. 2408, provided that: ''Chapter 35 of title 44, United States Code, shall not apply, until January 1, 1984, to collection of information and information collection requests which the Secretary of Health and Human Services determines to be necessary to carry out the amendments made by this section [amendments by section 101(a) of Pub. L. 97–248, enacting this section and amending section 1395x of this title].''

§ 1395xx. Payment of provider-based physicians and payment under certain percentage arrangements

(a) Criteria; amount of payments

(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.

(b) Prohibition of recognition of payments under certain percentage agreements

(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this subchapter on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement.

(2) Paragraph (1) shall not apply—

(A) to services furnished by a physician and described in subsection (a)(1)(B) and covered by regulations in effect under subsection (a), and

(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

(i) is a customary commercial business practice, or

(ii) provides incentives for the efficient and economical operation of the provider of services.

(Aug. 14, 1935, ch. 531, title XVIII, § 1887, as added and amended Pub. L. 97–248, title I, §§ 108(a)[(1)], 109(a), Sept. 3, 1982, 96 Stat. 337, 338; Pub. L. 98–21, title VI, § 602(j), Apr. 20, 1983, 97 Stat. 165.)

Editorial Notes

AMENDMENTS

1983—Subsec. (a)(1)(B). Pub. L. 98–21 inserted ''or on the bases described in section 1395ww of this title''.

1982—Subsec. (b). Pub. L. 97–248, § 109(a)(2), added subsec. (b).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, § 109(c)(1), (2), Sept. 3, 1982, 96 Stat. 339, provided that:

''(1) The amendments made by this section [amending this section and section 1395x of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], except that section 1887(b)(1) of the Social Security Act [42 U.S.C. 1395xx(b)(1)] shall not apply before October 1, 1982, to services furnished by a physician and described in section 1887(a)(1)(B) of such Act [42 U.S.C. 1395xx(a)(1)(B)].

''(2) In the case of a contract with a provider of services entered into prior to the date of the enactment of this Act [Sept. 3, 1982], the amendment made by subsection (a) [amending this section] shall apply to payments under such contract (A) 30 days after the first date (after such date of enactment) the provider of services may unilaterally terminate the contract, or (B) one year after the date of the enactment of this Act, whichever is earlier.''

EFFECTIVE DATE OF REGULATIONS

Pub. L. 97–248, title I, § 108(b), formerly § 108(c), Sept. 3, 1982, 96 Stat. 338, as redesignated by Pub. L. 97–448, title III, § 309(a)(3), Jan. 12, 1983, 96 Stat. 2408, provided that: ''The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act [42 U.S.C. 1395xx(a)] not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to a hospital or skilled nursing facility resulting from such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.''

§ 1395yy. Payment to skilled nursing facilities for routine service costs

(a) Per diem limitations

The Secretary, in determining the amount of the payments which may be made under this subchapter with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.

(2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.

(3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods beginning on or after October 1, 1992, on or after October 1, 1995, and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.

(b) Excess overhead allocations for hospital-based facilities

With respect to a hospital-based skilled nursing facility, the Secretary may not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations.

(c) Adjustments in limitations; publication of data

The Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

(d) Access to skilled nursing facilities

(1) Subject to subsection (e), any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) and capital-related costs of extended care services provided in a cost reporting period if such facility had, in the preceding cost reporting period, fewer than 1,500 patient days with respect to which payments were made under this subchapter. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1395x(v) of this title and subsections (a) through (c) of this section and capital-related costs pursuant to section 1395x(v) of this title. This subsection shall not apply to a facility for any cost reporting period immediately following a cost reporting period in which such facility had 1,500 or more patient days with respect to which payments were made under this subchapter, without regard to whether payments were made under this subsection during such preceding cost reporting period.

(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels, and

(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels.

(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term ''region'' shall have the same meaning as under section 1395ww(d)(2)(D) of this title.

(4) The Secretary shall establish the prospective payment amounts for cost reporting periods beginning in a fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis

of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a cost reporting period no later than 30 days before the beginning of that period.

(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.

(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1395x(v)(1)(E) of this title (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(e) Prospective payment

(1) Payment provision

Notwithstanding any other provision of this subchapter, subject to paragraphs (7), (11), and (12), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

(2) Definitions

For purposes of this subsection:

(A) Covered skilled nursing facility services

(i) In general

The term ''covered skilled nursing facility services''—

(I) means post-hospital extended care services as defined in section 1395x(i) of this title for which benefits are provided under part A; and

(II) includes all items and services (other than items and services described in clauses (ii), (iii), and (iv)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

(ii) Services excluded

Services described in this clause are physicians' services, services described by clauses (i) and (ii) of section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1395x(s)(2) of this title, telehealth services furnished under section 1395m(m)(4)(C)(ii)(VII) of this title, and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

(iii) Exclusion of certain additional items and services

Items and services described in this clause are the following:

(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1395x(s)(2)(F) of this title.

(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)) and any additional chemotherapy items identified by the Secretary.

(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)) and any additional chemotherapy administration services identified by the Secretary.

(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)) and any additional radioisotope services identified by the Secretary.

(V) Customized prosthetic devices (commonly known as artificial limbs or components of artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.

(VI) Blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders (identified as of July 1, 2020, by HCPCS codes J7170, J7175, J7177–J7183, J7185–J7190, J7192–J7195, J7198–J7203, J7205, J7207–J7211, and as subsequently modified by the Secretary) and items and services related to the furnishing of such factors under section 1395u(*o*)(5)(C) of this title, and any additional blood clotting factors identified by the Secretary and items and services related to the furnishing of such factors under such section.

(iv) Exclusion of certain rural health clinic and federally qualified health center services

Services described in this clause are—

(I) rural health clinic services (as defined in paragraph (1) of section 1395x(aa) of this title); and

(II) federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a federally qualified health center.

(B) All costs

The term ''all costs'' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

(C) Non-Federal percentage; Federal percentage

For—

(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the ''non-Federal percentage'' is 75 percent and the ''Federal percentage'' is 25 percent;

(ii) the next cost reporting period of such facility, the ''non-Federal percentage'' is 50 percent and the ''Federal percentage'' is 50 percent; and

(iii) the subsequent cost reporting period of such facility, the ''non-Federal percentage'' is 25 percent and the ''Federal percentage'' is 75 percent.

(D) First cost reporting period

The term ''first cost reporting period'' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

(E) Transition period

(i) In general

The term ''transition period'' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

(ii) Treatment of new skilled nursing facilities

In the case of a skilled nursing facility that first received payment for services under this subchapter on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

(3) Determination of facility specific per diem rates

The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

(A) Determining base payments

The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non-settled cost reports or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during the applicable cost reporting period described in clause (i) to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exceptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

(B) Update to first cost reporting period

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1.0 percentage point.

(C) Updating to applicable cost reporting period

The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility-specific update factor.

(D) Facility-specific update factor

For purposes of this paragraph, the ''facility-specific update factor'' for cost reporting periods beginning during—

(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility

market basket percentage increase for such fiscal year minus 1 percentage point, and

(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

(4) Federal per diem rate

(A) Determination of historical per diem for facilities

For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) Update to first fiscal year

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

(C) Computation of standardized per diem rate

The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

(ii) adjusting for variations in case mix per diem among facilities.

(D) Computation of weighted average per diem rates

(i) All facilities

The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(ii) Freestanding facilities

The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(iii) Separate computation

The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1395ww(d)(2)(D) of this title).

(E) Updating

(i) Initial period

For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted Federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

(ii) Subsequent fiscal years

The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

(II) for fiscal year 2001, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year;

(III) for each of fiscal years 2002 and 2003, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 0.5 percentage points; and

(IV) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

(F) Adjustment for case mix creep

Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(G) Determination of Federal rate

The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

(i) Adjustment for case mix

The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

(ii) Adjustment for geographic variations in labor costs

The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

(iii) Adjustment for exclusion of certain additional items and services

The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).

(H) Publication of information on per diem rates

The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

(5) Skilled nursing facility market basket index and percentage

For purposes of this subsection:

(A) Skilled nursing facility market basket index

The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

(B) Skilled nursing facility market basket percentage

(i) In general

Subject to clauses (ii), (iii), and (iv), the term ''skilled nursing facility market basket percentage'' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(ii) Adjustment

For fiscal year 2012 and each subsequent fiscal year, subject to clauses (iii) and (iv), after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Special rule for fiscal year 2018

For fiscal year 2018 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 1 percent.

(iv) Special rule for fiscal year 2019

For fiscal year 2019 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 2.4 percent.

(6) Reporting of assessment and quality data

(A) Reduction in update for failure to report

(i) In general

For fiscal years beginning with fiscal year 2018, in the case of a skilled nursing facility that does not submit data, as applicable, in accordance with subclauses (II) and (III) of subparagraph (B)(i) with respect to such a fiscal year, after determining the percentage described in paragraph (5)(B)(i), and after application of clauses (ii) and (iii) of paragraph (5)(B), the Secretary shall reduce such percentage for payment rates during such fiscal year by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in the percentage described in paragraph (5)(B)(i), after application of

clauses (ii) and (iii) of paragraph (5)(B), being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Noncumulative application

Any reduction under clause (i) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(B) Assessment and measure data

(i) In general

A skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), shall submit to the Secretary, in a manner and within the timeframes prescribed by the Secretary—

(I) subject to clause (iii), the resident assessment data necessary to develop and implement the rates under this subsection;

(II) for fiscal years beginning on or after the specified application date (as defined in subsection (a)(2)(E) of section 1395*lll* of this title), as applicable with respect to skilled nursing facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, data on such quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1); and

(III) for fiscal years beginning on or after October 1, 2018, standardized patient assessment data required under subsection (b)(1) of section 1395*lll* of this title.

(ii) Use of standard instrument

For purposes of meeting the requirement under clause (i), a skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), may submit the resident assessment data required under section 1395i–3(b)(3) of this title, using the standard instrument designated by the State under section 1395i–3(e)(5) of this title.

(iii) Non-duplication

To the extent data submitted under subclause (II) or (III) of clause (i) duplicates other data required to be submitted under clause (i)(I), the submission of such data under such a subclause shall be in lieu of the submission of such data under clause (i)(I). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395*lll* of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(7) Treatment of medicare swing bed hospitals

(A) Transition

Subject to subparagraph (C), the Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B) (other than critical access hospitals), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

(B) Facilities described

The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1395tt of this title.

(C) Exemption from PPS of swing-bed services furnished in critical access hospitals

The prospective payment system established under this subsection shall not apply to services furnished by a critical access hospital pursuant to an agreement under section 1395tt of this title.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of—

(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii);

(B) the establishment of facility specific rates before July 1, 1999 (except any determination of costs paid under part A of this subchapter); and

(C) the establishment of transitional amounts under paragraph (7).

(9) Payment for certain services

In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1395*l*(a)(2)(B) of this title, the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service. In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395i of this title (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title).

(10) Required coding

No payment may be made under part B for items and services (other than services de-

scribed in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.

(11) Permitting facilities to waive 3-year transition

Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning no earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).

(12) Adjustment for residents with AIDS

(A) In general

Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), shall be increased by 128 percent to reflect increased costs associated with such residents.

(B) Sunset

Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.

(f) Reporting of direct care expenditures

(1) In general

For cost reports submitted under this subchapter for cost reporting periods beginning on or after the date that is 2 years after March 23, 2010, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

(2) Modification of form

The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after March 23, 2010.

(3) Categorization by functional accounts

Not later than 30 months after March 23, 2010, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

(A) Spending on direct care services (including nursing, therapy, and medical services).

(B) Spending on indirect care (including housekeeping and dietary services).

(C) Capital assets (including building and land costs).

(D) Administrative services costs.

(4) Availability of information submitted

The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.

(g) Skilled nursing facility readmission measure

(1) Readmission measure

Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).

(2) Resource use measure

Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.

(3) Measure adjustments

When specifying the measures under paragraphs (1) and (2), the Secretary shall devise a methodology to achieve a high level of reliability and validity, especially for skilled nursing facilities with a low volume of readmissions.

(4) Pre-rulemaking process (measure application partnership process)

The application of the provisions of section 1395aaa–1 of this title shall be optional in the case of a measure specified under paragraph (1) and a measure specified under paragraph (2).

(5) Feedback reports to skilled nursing facilities

Beginning October 1, 2016, and every quarter thereafter, the Secretary shall provide confidential feedback reports to skilled nursing facilities on the performance of such facilities with respect to a measure specified under paragraph (1) or (2).

(6) Public reporting of skilled nursing facilities

(A) In general

Subject to subparagraphs (B) and (C), the Secretary shall establish procedures for making available to the public by posting on the Nursing Home Compare Medicare website (or a successor website) described in

section 1395i–3(i) of this title information on the performance of skilled nursing facilities with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2).

(B) Opportunity to review

The procedures under subparagraph (A) shall ensure that a skilled nursing facility has the opportunity to review and submit corrections to the information that is to be made public with respect to the facility prior to such information being made public.

(C) Timing

Such procedures shall provide that the information described in subparagraph (A) is made publicly available beginning not later than October 1, 2017.

(7) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 (commonly referred to as the ''Paperwork Reduction Act of 1995'') shall not apply to this subsection.

(h) Skilled nursing facility value-based purchasing program

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish a skilled nursing facility value-based purchasing program (in this subsection referred to as the ''SNF VBP Program'') under which value-based incentive payments are made in a fiscal year to skilled nursing facilities.

(B) Program to begin in fiscal year 2019

The SNF VBP Program shall apply to payments for services furnished on or after October 1, 2018.

(C) Exclusions

With respect to payments for services furnished on or after October 1, 2022, this subsection shall not apply to a facility for which there are not a minimum number (as determined by the Secretary) of—

(i) cases for the measures that apply to the facility for the performance period for the applicable fiscal year; or

(ii) measures that apply to the facility for the performance period for the applicable fiscal year.

(2) Application of measures

(A) In general

The Secretary—

(i) shall apply the measure specified under subsection (g)(1) for purposes of the SNF VBP Program; and

(ii) may, with respect to payments for services furnished on or after October 1, 2023, apply additional measures determined appropriate by the Secretary, which may include measures of functional status, patient safety, care coordination, or patient experience.

Subject to the succeeding sentence, in the case that the Secretary applies additional measures under clause (ii), the Secretary shall consider and apply, as appropriate, quality measures specified under section 1395*lll*(c)(1) of this title. In no case may the Secretary apply more than 10 measures under this subparagraph.

(B) Replacement

For purposes of the SNF VBP Program, the Secretary shall apply the measure specified under (g)(2)[1] instead of the measure specified under (g)(1)[1] as soon as practicable.

(3) Performance standards

(A) Establishment

The Secretary shall establish performance standards with respect to the measures applied under paragraph (2) for a performance period for a fiscal year.

(B) Higher of achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement. In calculating the SNF performance score under paragraph (4), the Secretary shall use the higher of either improvement or achievement.

(C) Timing

The Secretary shall establish and announce the performance standards established under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(4) SNF performance score

(A) In general

The Secretary shall develop a methodology for assessing the total performance of each skilled nursing facility based on performance standards established under paragraph (3) with respect to the measures applied under paragraph (2). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ''SNF performance score'') for each skilled nursing facility for each such performance period.

(B) Ranking of SNF performance scores

The Secretary shall, for the performance period for each fiscal year, rank the SNF performance scores determined under subparagraph (A) from low to high.

(5) Calculation of value-based incentive payments

(A) In general

With respect to a skilled nursing facility, based on the ranking under paragraph (4)(B) for a performance period for a fiscal year, the Secretary shall increase the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility (and after application of paragraph (6)) for services furnished by such facility during such fiscal year by the value-based incentive payment amount under subparagraph (B).

[1] So in original. Probably should be preceded by ''subsection''.

(B) Value-based incentive payment amount

The value-based incentive payment amount for services furnished by a skilled nursing facility in a fiscal year shall be equal to the product of—

(i) the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility for such services furnished by the skilled nursing facility during such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the skilled nursing facility for such fiscal year.

(C) Value-based incentive payment percentage

(i) In general

The Secretary shall specify a value-based incentive payment percentage for a skilled nursing facility for a fiscal year which may include a zero percentage.

(ii) Requirements

In specifying the value-based incentive payment percentage for each skilled nursing facility for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the SNF performance score of the skilled nursing facility provided under paragraph (4) for the performance period for such fiscal year;

(II) the application of all such percentages in such fiscal year results in an appropriate distribution of value-based incentive payments under subparagraph (B) such that—

(aa) skilled nursing facilities with the highest rankings under paragraph (4)(B) receive the highest value-based incentive payment amounts under subparagraph (B);

(bb) skilled nursing facilities with the lowest rankings under paragraph (4)(B) receive the lowest value-based incentive payment amounts under subparagraph (B); and

(cc) in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection; and

(III) the total amount of value-based incentive payments under this paragraph for all skilled nursing facilities in such fiscal year shall be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for such fiscal year under paragraph (6), as estimated by the Secretary.

(6) Funding for value-based incentive payments

(A) In general

The Secretary shall reduce the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to a skilled nursing facility for services furnished by such facility during a fiscal year (beginning with fiscal year 2019) by the applicable percent (as defined in subparagraph (B)). The Secretary shall make such reductions for all skilled nursing facilities in the fiscal year involved, regardless of whether or not the skilled nursing facility has been determined by the Secretary to have earned a value-based incentive payment under paragraph (5) for such fiscal year.

(B) Applicable percent

For purposes of subparagraph (A), the term ''applicable percent'' means, with respect to fiscal year 2019 and succeeding fiscal years, 2 percent.

(7) Announcement of net result of adjustments

Under the SNF VBP Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each skilled nursing facility of the adjustments to payments to the skilled nursing facility for services furnished by such facility during the fiscal year under paragraphs (5) and (6).

(8) No effect in subsequent fiscal years

The value-based incentive payment under paragraph (5) and the payment reduction under paragraph (6) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a skilled nursing facility under this section in a subsequent fiscal year.

(9) Public reporting

(A) SNF specific information

The Secretary shall make available to the public, by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1395i–3(i) of this title in an easily understandable format, information regarding the performance of individual skilled nursing facilities under the SNF VBP Program, with respect to a fiscal year, including—

(i) the SNF performance score of the skilled nursing facility for such fiscal year; and

(ii) the ranking of the skilled nursing facility under paragraph (4)(B) for the performance period for such fiscal year.

(B) Aggregate information

The Secretary shall periodically post on the Nursing Home Compare Medicare website (or a successor website) described in section 1395i–3(i) of this title aggregate information on the SNF VBP Program, including—

(i) the range of SNF performance scores provided under paragraph (4)(A); and

(ii) the number of skilled nursing facilities receiving value-based incentive pay-

ments under paragraph (5) and the range and total amount of such value-based incentive payments.

(10) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(A) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under paragraph (5).

(B) The determination of the amount of funding available for such value-based incentive payments under paragraph (5)(C)(ii)(III) and the payment reduction under paragraph (6).

(C) The establishment of the performance standards under paragraph (3) and the performance period.

(D) The methodology developed under paragraph (4) that is used to calculate SNF performance scores and the calculation of such scores.

(E) The ranking determinations under paragraph (4)(B).

(11) Funding for program management

The Secretary shall provide for the one time transfer from the Federal Hospital Insurance Trust Fund established under section 1395i of this title to the Centers for Medicare & Medicaid Services Program Management Account of—

(A) for purposes of subsection (g)(2), $2,000,000; and

(B) for purposes of implementing this subsection, $10,000,000.

Such funds shall remain available until expended.

(12) Validation

(A) In general

The Secretary shall apply to the measures applied under this subsection and the data submitted under subsection (e)(6) a process to validate such measures and data, as appropriate, which may be similar to the process specified in section 1395ww(b)(3)(B)(viii)(XI) of this title for validating inpatient hospital measures.

(B) Funding

For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1395i of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2023 through 2025, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1888, as added Pub. L. 98–369, div. B, title III, § 2319(b), July 18, 1984, 98 Stat. 1082; amended Pub. L. 99–272, title IX, §§ 9126(a), (b), 9219(b)(1)(C), Apr. 7, 1986, 100 Stat. 168, 170, 182; Pub. L. 99–514, title XVIII, § 1895(b)(7)(A), (B), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, § 4201(b)(2), Dec. 22, 1987, 101 Stat. 1330–174; Pub. L. 101–508, title IV, § 4008(e)(2), (h)(2)(A)(ii), Nov. 5, 1990, 104 Stat. 1388–45, 1388–48; Pub. L. 103–66, title XIII, § 13503(a)(2), (3)(A), Aug. 10, 1993, 107 Stat. 578; Pub. L. 105–33, title IV, §§ 4431, 4432(a), (b)(3), (5)(H), 4511(a)(2)(E), Aug. 5, 1997, 111 Stat. 414, 421, 422, 442; Pub. L. 106–113, div. B, § 1000(a)(6) [title I, §§ 102(a), 103(a), (b), 104(a), 105(a), title III, § 321(g)(1), (k)(18)], Nov. 29, 1999, 113 Stat. 1536, 1501A–325 to 1501A–327, 1501A–366, 1501A–368; Pub. L. 106–554, § 1(a)(6) [title II, § 203(a), title III, § 311(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, 2763A–497; Pub. L. 108–173, title IV, § 410(a), title V, § 511(a), Dec. 8, 2003, 117 Stat. 2271, 2298; Pub. L. 110–275, title I, § 149(b), July 15, 2008, 122 Stat. 2549; Pub. L. 111–148, title III, § 3401(b), title VI, § 6104, Mar. 23, 2010, 124 Stat. 481, 711; Pub. L. 113–93, title II, § 215(a), (b), Apr. 1, 2014, 128 Stat. 1048, 1049; Pub. L. 113–185, § 2(c)(4)(A), Oct. 6, 2014, 128 Stat. 1965; Pub. L. 114–10, title IV, § 411(a), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title XII, § 53111, Feb. 9, 2018, 132 Stat. 304; Pub. L. 116–260, div. CC, title I, §§ 111(a), 134(a), Dec. 27, 2020, 134 Stat. 2944, 2977.)

Editorial Notes

REFERENCES IN TEXT

Section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (e)(12)(A), is section 1000(a)(6) [title I, § 101] of Pub. L. 106–113, div. B, Nov. 29, 1999, 113 Stat. 1536, 1501A–324, which is not classified to the Code.

Section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (e)(12)(A), is section 1(a)(6) [title III, § 314(a)] of Pub. L. 106–554, Dec. 21, 2000, 114 Stat. 2763, 2763A–499, which is not classified to the Code.

AMENDMENTS

2020—Subsec. (e)(2)(A)(iii)(VI). Pub. L. 116–260, § 134(a), added subcl. (VI).

Subsec. (h)(1)(C). Pub. L. 116–260, § 111(a)(1), added subpar. (C).

Subsec. (h)(2)(A). Pub. L. 116–260, § 111(a)(2), inserted dash after ''The Secretary'' and cl. (i) designation before ''shall apply'', substituted ''Program; and'' for ''Program.'', added cl. (ii), and inserted concluding provisions.

Subsec. (h)(3)(A), (4)(A). Pub. L. 116–260, § 111(a)(3), substituted ''measures'' for ''measure''.

Subsec. (h)(12). Pub. L. 116–260, § 111(a)(4), added par. (12).

2018—Subsec. (e)(5)(B)(i). Pub. L. 115–123, § 53111(1), substituted '', (iii), and (iv)'' for ''and (iii)''.

Subsec. (e)(5)(B)(ii). Pub. L. 115–123, § 53111(2), substituted ''clauses (iii) and (iv)'' for ''clause (iii)''.

Subsec. (e)(5)(B)(iv). Pub. L. 115–123, § 53111(3), added cl. (iv).

2015—Subsec. (e)(5)(B)(i). Pub. L. 114–10, § 411(a)(1)(A), substituted ''clauses (ii) and (iii)'' for ''clause (ii)''.

Subsec. (e)(5)(B)(ii). Pub. L. 114–10, § 411(a)(1)(B), inserted ''subject to clause (iii),'' after ''each subsequent fiscal year,''.

Subsec. (e)(5)(B)(iii). Pub. L. 114–10, § 411(a)(1)(C), added cl. (iii).

Subsec. (e)(6)(A)(i), (ii). Pub. L. 114–10, § 411(a)(2), substituted ''clauses (ii) and (iii) of paragraph (5)(B)'' for ''paragraph (5)(B)(ii)''.

2014—Subsec. (e)(6). Pub. L. 113–185 amended par. (6) generally. Prior to amendment, text read as follows: ''A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing

facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1395i–3(b)(3) of this title, using the standard instrument designated by the State under section 1395i–3(e)(5) of this title.''

Subsec. (g). Pub. L. 113–93, §215(a), added subsec. (g).

Subsec. (h). Pub. L. 113–93, §215(b), added subsec. (h).

2010—Subsec. (e)(5)(B). Pub. L. 111–148, §3401(b), designated existing provisions as cl. (i), inserted heading, substituted ''Subject to clause (ii), the term'' for ''The term'', and added cl. (ii).

Subsec. (f). Pub. L. 111–148, §6104, added subsec. (f).

2008—Subsec. (e)(2)(A)(ii). Pub. L. 110–275 inserted ''telehealth services furnished under section 1395m(m)(4)(C)(ii)(VII) of this title,'' after ''section 1395x(s)(2) of this title,''.

2003—Subsec. (e)(2)(A)(i)(II). Pub. L. 108–173, §410(a)(1), substituted ''clauses (ii), (iii), and (iv)'' for ''clauses (ii) and (iii)''.

Subsec. (e)(2)(A)(iv). Pub. L. 108–173, §410(a)(2), added cl. (iv).

Subsec. (e)(12). Pub. L. 108–173, §511(a), amended heading and text of par. (12) generally, substituting provisions relating to upward adjustment of per diem payment for residents of a skilled nursing facility with AIDS for provisions relating to per diem payment rule for certain qualified acute skilled nursing facilities.

2000—Subsec. (e)(4)(E)(ii)(II). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(3)], added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (e)(4)(E)(ii)(III). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(1), (2)], redesignated subcl. (II) as (III) and substituted ''each of fiscal years 2002 and 2003'' for ''each of fiscal years 2001 and 2002'' and ''minus 0.5 percentage points'' for ''minus 1 percentage point''. Former subcl. (III) redesignated (IV).

Subsec. (e)(4)(E)(ii)(IV). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(1)], redesignated subcl. (III) as (IV).

Subsec. (e)(7). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(1)], substituted ''Treatment of'' for ''Transition for'' in heading.

Subsec. (e)(7)(A). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(2), (3)], in heading substituted ''Transition'' for ''In general'' and in text substituted ''Subject to subparagraph (C), the'' for ''The'' and inserted ''(other than critical access hospitals)'' after ''facilities described in subparagraph (B)''.

Subsec. (e)(7)(B). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(4)], struck out '', for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1395f(*l*) of this title (as in effect on and after such date)'' before period at end.

Subsec. (e)(7)(C). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(5)], added subpar. (C).

1999—Subsec. (e)(1). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(1)], substituted ''subject to paragraphs (7), (11), and (12)'' for ''subject to paragraphs (7) and (11)'' in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title I, §102(a)(1)], substituted ''paragraphs (7) and (11)'' for ''paragraph (7)'' in introductory provisions.

Subsec. (e)(2)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(1)], substituted ''items and services described in clauses (ii) and (iii)'' for ''services described in clause (ii)''.

Subsec. (e)(2)(A)(iii). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(2)], added cl. (iii).

Subsec. (e)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(A)], inserted ''or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997'' after ''to non-settled cost reports''.

Subsec. (e)(3)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(B)], substituted ''furnished during the applicable cost reporting period described in clause (i)'' for ''furnished during such period''.

Subsec. (e)(3)(B). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(2)], added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows:

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

''(ii) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997.''

Subsec. (e)(4)(E)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(18)(A)], substituted ''Federal'' for ''federal''.

Subsec. (e)(4)(E)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(18)(B)], substituted ''Federal'' for ''federal'' in two places in introductory provisions.

Subsec. (e)(4)(G)(iii). Pub. L. 106–113, §1000(a)(6) [title I, §103(b)(1)], added cl. (iii).

Subsec. (e)(8)(A). Pub. L. 106–113, §1000(a)(6) [title I, §103(b)(2)], substituted ''adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii)'' for ''and adjustments for variations in labor-related costs under paragraph (4)(G)(ii)''.

Subsec. (e)(8)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(g)(1)], substituted ''July 1, 1999'' for ''January 1, 1999,''.

Subsec. (e)(9). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(3)], inserted at end ''In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395i of this title (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title).''

Subsec. (e)(11). Pub. L. 106–113, §1000(a)(6) [title I, §102(a)(2)], added par. (11).

Subsec. (e)(12). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(2), (b)], temporarily added par. (12).

1997—Subsec. (a). Pub. L. 105–33, §4431, substituted ''described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.'' for ''described in this subsection'' at end.

Subsec. (d)(1). Pub. L. 105–33, §4432(b)(5)(H), substituted ''Subject to subsection (e), any skilled nursing facility'' for ''Any skilled nursing facility''.

Subsec. (e). Pub. L. 105–33, §4432(a), added subsec. (e).

Subsec. (e)(2)(A)(ii). Pub. L. 105–33, §4511(a)(2)(E), substituted ''and (ii)'' for ''through (iii)''.

Subsec. (e)(9), (10). Pub. L. 105–33, §4432(b)(3), added pars. (9) and (10).

1993—Subsec. (a). Pub. L. 103–66, §13503(a)(2), inserted '', on or after October 1, 1995,'' after ''October 1, 1992'' in concluding provisions.

Subsec. (b). Pub. L. 103–66, §13503(a)(3)(A), substituted ''Secretary may not recognize'' for ''Secretary shall recognize'' and a period for ''(as determined by the Secretary) resulting from the reimbursement principles under this subchapter, notwithstanding the limits set forth in paragraph (3) or (4) of subsection (a) of this section.''

1990—Subsec. (a). Pub. L. 101–508, §4008(e)(2), struck out period at end and inserted '', and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection''.

Subsec. (d)(1). Pub. L. 101–508, §4008(h)(2)(A)(ii), substituted ''(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) and capital-related costs'' for ''(and capital-related costs)''.

1987—Subsec. (d)(7). Pub. L. 100–203 added par. (7).

1986—Subsec. (b). Pub. L. 99–272, §9219(b)(1)(C), substituted ''notwithstanding'' for ''nothwithstanding''.

Subsec. (c). Pub. L. 99–272, § 9126(b), inserted provision requiring the Secretary to publish data and criteria to be used for purposes of this subsection on an annual basis.

Subsec. (d). Pub. L. 99–272, § 9126(a), added subsec. (d).

Subsec. (d)(1). Pub. L. 99–514, § 1895(b)(7)(A), substituted ''cost reporting period'' for ''fiscal year'' in five places.

Subsec. (d)(4). Pub. L. 99–514, § 1895(b)(7)(B), substituted ''cost reporting periods beginning in a fiscal year'' for ''each fiscal year'' and ''cost reporting period no later than 30 days before the beginning of that period'' for ''fiscal year within 60 days after the Secretary establishes the final prospective payment amounts for such fiscal year''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, § 134(b), Dec. 27, 2020, 134 Stat. 2977, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to items and services furnished on or after October 1, 2021.''

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 149(c) of Pub. L. 110–275, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, § 410(b), Dec. 8, 2003, 117 Stat. 2271, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 2005.''

Pub. L. 108–173, title V, § 511(b), Dec. 8, 2003, 117 Stat. 2299, provided that: ''The amendment made by paragraph (1) [probably should be ''subsection (a)'', amending this section] shall apply to services furnished on or after October 1, 2004.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title II, § 203(a)] of Pub. L. 106–554 applicable to cost reporting periods beginning on or after Dec. 21, 2001, see section 1(a)(6) [title IV, § 203(c)] of Pub. L. 106–554, set out as a note under section 1395tt of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 102(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–325, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to elections made on or after December 15, 1999, except that no election shall be effective under such amendments for a cost reporting period beginning before January 1, 2000.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 103(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–326, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payments made for items and services furnished on or after April 1, 2000.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 104(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–327, provided that: ''The amendments made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4432(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 105(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that: ''The amendments made by subsection (a) [amending this section] shall apply for the period beginning on the date on which the first cost reporting period of the facility begins after the date of the enactment of this Act [Nov. 29, 1999] and ending on September 30, 2001, and applies to skilled nursing facilities furnishing covered skilled nursing facility services on the date of the enactment of this Act for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

Amendment by section 1000(a)(6) [title III, § 321(g)(1), (k)(18)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4432(a), (b)(3), (5)(H) of Pub. L. 105–33 effective for cost reporting periods beginning on or after July 1, 1998, except that amendment by section 4432(b) applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(a)(2)(E) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, § 13503(a)(3)(B), Aug. 10, 1993, 107 Stat. 578, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1993.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, § 4008(e)(3), Nov. 5, 1990, 104 Stat. 1388–45, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and provisions set out as a note below] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239].''

Amendment by section 4008(h)(2)(A)(ii) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4008(h)(2)(P) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, § 1895(b)(7)(D), Oct. 22, 1986, 100 Stat. 2933, provided that: ''The amendments made by subparagraphs (A) and (B) [amending this section] apply to cost reporting periods beginning on or after October 1, 1986.''

Amendment by section 9219(b)(1)(C) of Pub. L. 99–272 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 9219(b)(1)(D) of Pub. L. 99–272, set out as a note under section 1395u of this title.

Pub. L. 99–272, title IX, § 9126(d), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 99–514, title XVIII, § 1895(b)(7)(C), Oct. 22, 1986, 100 Stat. 2933, provided that:

''(1) The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986.

''(2) The amendment made by subsection (b) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

EFFECTIVE DATE

Pub. L. 98–369, div. B, title III, § 2319(c), July 18, 1984, 98 Stat. 1083, provided that: ''The amendments made by subsections (a) [amending section 1395x of this title]

and (b) [enacting this section] shall apply to cost reporting periods beginning on or after July 1, 1984.''

STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND SERVICES FOR BENEFICIARIES IN SKILLED NURSING FACILITIES

Pub. L. 108–173, title V, §513, Dec. 8, 2003, 117 Stat. 2300, directed the Comptroller General of the United States to conduct a study of portable diagnostic ultrasound services furnished to medicare beneficiaries in skilled nursing facilities and to submit to Congress a report on the study not later than 2 years after Dec. 8, 2003.

SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001

Pub. L. 106–554, §1(a)(6) [title III, §311(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–497, provided that: ''Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001, the Federal per diem rate referred to in paragraph (4)(E)(ii) of such section—

''(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

''(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate that would have been determined under such section if 'plus 1 percentage point' had been substituted for 'minus 1 percentage point' under subclause (II) of such paragraph (as in effect on the day before the date of the enactment of this Act).''

Pub. L. 106–554, §1(a)(6) [title V, §547(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that: ''The payment increase provided under section 311(b)(2) [set out as a note above] (relating to covered skilled nursing facility services) shall not apply to services furnished after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for services furnished after such fiscal year.''

GAO REPORT ON ADEQUACY OF SNF PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title III, §311(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that: ''Not later than July 1, 2002, the Comptroller General of the United States shall submit to Congress a report on the adequacy of medicare payment rates to skilled nursing facilities and the extent to which medicare contributes to the financial viability of such facilities. Such report shall take into account the role of private payors, medicaid, and case mix on the financial performance of these facilities, and shall include an analysis (by specific RUG classification) of the number and characteristics of such facilities.''

HCFA STUDY OF CLASSIFICATION SYSTEMS FOR SNF RESIDENTS

Pub. L. 106–554, §1(a)(6) [title III, §311(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the different systems for categorizing patients in medicare skilled nursing facilities in a manner that accounts for the relative resource utilization of different patient types.

''(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under subsection (a). Such report shall include such recommendations regarding changes in law as may be appropriate.''

GAO AUDIT OF NURSING STAFF RATIOS

Pub. L. 106–554, §1(a)(6) [title III, §312(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that:

''(1) AUDIT.—The Comptroller General of the United States shall conduct an audit of nursing staffing ratios in a representative sample of medicare skilled nursing facilities. Such sample shall cover selected States and shall include broad representation with respect to size, ownership, location, and medicare volume. Such audit shall include an examination of payroll records and medicaid cost reports of individual facilities.

''(2) REPORT.—Not later than August 1, 2002, the Comptroller General shall submit to Congress a report on the audits conducted under paragraph (1). Such report shall include an assessment of the impact of the increased payments under this subtitle [subtitle B, §§311–315, of title III of §1(a)(6) of Pub. L. 106–554, amending this section and sections 1395u, 1395y, and 1395cc of this title and enacting provisions set out as notes under this section and section 1395u of this title] on increased nursing staff ratios and shall make recommendations as to whether increased payments under subsection (a) [114 Stat. 2763A–498] should be continued.''

OVERSIGHT

Pub. L. 106–554, §1(a)(6) [title III, §313(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499, provided that: ''The Secretary of Health and Human Services, through the Office of the Inspector General in the Department of Health and Human Services or otherwise, shall monitor payments made under part B of the title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for items and services furnished to residents of skilled nursing facilities during a time in which the residents are not being provided medicare covered post-hospital extended care services to ensure that there is not duplicate billing for services or excessive services provided.''

ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC RECLASSIFICATION

Pub. L. 106–554, §1(a)(6) [title III, §315], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services may establish a procedure for the geographic reclassification of a skilled nursing facility for purposes of payment for covered skilled nursing facility services under the prospective payment system established under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)). Such procedure may be based upon the method for geographic reclassifications for inpatient hospitals established under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)).

''(b) REQUIREMENT FOR SKILLED NURSING FACILITY WAGE DATA.—In no case may the Secretary implement the procedure under subsection (a) before such time as the Secretary has collected data necessary to establish an area wage index for skilled nursing facilities based on wage data from such facilities.''

REPORT TO CONGRESS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §105(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that: ''Not later than March 1, 2001, the Secretary of Health and Human Services shall assess the resource use of patients of skilled nursing facilities furnishing services under the medicare program who are immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary (under paragraph (12)(C), as added by subsection (a), of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))) to determine whether any permanent adjustments are needed to the RUGs to take into account the resource uses and costs of these patients.''

MEDICAL REVIEW PROCESS

Pub. L. 105–33, title IV, §4432(c), Aug. 5, 1997, 111 Stat. 422, provided that: ''In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section [amending this section and sections 1395i–3, 1395k, 1395*l*, 1395u, 1395x,

1395y, 1395cc, and 1395tt of this title] on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].''

CONSTRUCTION OF WAGE INDEX FOR SKILLED NURSING FACILITIES

Pub. L. 103–432, title I, § 106(a), Oct. 31, 1994, 108 Stat. 4405, provided that: ''Not later than 1 year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary of Health and Human Services shall begin to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under section 1888(a)(4) of the Social Security Act [42 U.S.C. 1395yy(a)(4)].''

NO CHANGE IN LIMITS ON PER DIEM SERVICE COSTS FOR EXTENDED CARE SERVICES FOR FISCAL YEARS 1994 AND 1995

Pub. L. 103–66, title XIII, § 13503(a)(1), Aug. 10, 1993, 107 Stat. 578, provided that: ''The Secretary of Health and Human Services may not provide for any change in the limits on per diem routine service costs for extended care services under section 1888 of the Social Security Act [42 U.S.C. 1395yy] for cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendments made by paragraph (3)(A) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1888(c) of such Act to the payment limits for such services during such fiscal years.''

NO CHANGE IN PROSPECTIVE PAYMENTS FOR SERVICES FURNISHED DURING FISCAL YEARS 1994 AND 1995

Pub. L. 103–66, title XIII, § 13503(b), Aug. 10, 1993, 107 Stat. 578, provided that: ''The Secretary of Health and Human Services may not change the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act [42 U.S.C. 1395yy(d)] for services furnished during cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendment made by subsection (c)(1)(A) [amending section 1395x of this title].''

PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES

Pub. L. 101–508, title IV, § 4008(k), Nov. 5, 1990, 104 Stat. 1388–52, provided that:

''(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A [42 U.S.C. 1395c et seq.] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

''(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

''(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

''(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

''(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

''(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

''(2) REPORTS.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

''(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

''(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.''

USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES

Pub. L. 101–239, title VI, § 6024, Dec. 19, 1989, 103 Stat. 2167, as amended by Pub. L. 101–508, title IV, § 4008(e)(1), Nov. 5, 1990, 104 Stat. 1388–45, provided that: ''The Secretary of Health and Human Services shall determine mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act [42 U.S.C. 1395yy(a)] for cost reporting periods beginning on or after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning not earlier than October 1, 1985. The Secretary shall update such costs under such section for cost reporting periods beginning on or after October 1, 1989, by using cost reports submitted by skilled nursing facilities for cost reporting periods ending not earlier than January 31, 1988, and not later than December 31, 1988.''

§ 1395zz. Provider education and technical assistance

(a) Coordination of education funding

The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1395ddd of this title) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.

(b) Enhanced education and training

(1) Additional resources

There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

(2) Use

The funds made available under paragraph (1) shall be used to increase the conduct by

medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) Tailoring education and training activities for small providers or suppliers

(1) In general

Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

(2) Small provider of services or supplier

In this subsection, the term ''small provider of services or supplier'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(d) Internet websites; FAQs

The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

(1) provides answers in an easily accessible format to frequently asked questions, and

(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this subchapter (and subchapter XI insofar as it relates to such programs).

(e) Encouragement of participation in education program activities

A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(f) Construction

Nothing in this section or section 1395ddd(g) of this title shall be construed as providing for disclosure by a medicare contractor—

(1) of the screens used for identifying claims that will be subject to medical review; or

(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(g) Definitions

For purposes of this section, the term ''medicare contractor'' includes the following:

(1) A medicare administrative contractor with a contract under section 1395kk–1 of this title, including a fiscal intermediary with a contract under section 1395h of this title and a carrier with a contract under section 1395u of this title.

(2) An eligible entity with a contract under section 1395ddd of this title.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this subchapter or subchapter IX with respect to such activities and such provider of services or supplier.

(Aug. 14, 1935, ch. 531, title XVIII, §1889, as added and amended Pub. L. 108–173, title IX, §921(a)(1), (d)(1), (e)(1), (f)(1), Dec. 8, 2003, 117 Stat. 2388, 2391.)

Editorial Notes

PRIOR PROVISIONS

A prior section 1395zz, act Aug. 14, 1935, ch. 531, title XVIII, §1889, as added Nov. 5, 1990, Pub. L. 101–508, title IV, §4361(a), 104 Stat. 1388–141, related to medicare and medigap information by telephone, prior to repeal by Pub. L. 103–432, title I, §171(j)(3), (*l*), Oct. 31, 1994, 108 Stat. 4451, effective as if included in the enactment of Pub. L. 101–508.

Another prior section 1395zz, act Aug. 14, 1935, ch. 531, title XVIII, §1889, formerly §1833(f), as added Jan. 2, 1968, Pub. L. 90–248, title I, §132(b), 81 Stat. 850, and amended Oct. 30, 1972, Pub. L. 92–603, title II, §245(d), 86 Stat. 1424; Oct. 25, 1977, Pub. L. 95–142, §16(a), 91 Stat. 1200; renumbered §1889 and amended July 18, 1984, Pub. L. 98–369, div. B, title III, §2321(d), 98 Stat. 1084, provided for purchase of durable medical equipment, covering (a) lease-purchase basis or rental and determination by Secretary, (b) waiver of coinsurance amount in purchase of used equipment, (c) reimbursement procedures, and (d) encouragement of lease-purchase basis, prior to repeal by Pub. L. 100–203, title IV, §4062(d)(5), (e), Dec. 22, 1987, 101 Stat. 1330–109, applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

AMENDMENTS

2003—Subsecs. (b), (c). Pub. L. 108–173, §921(d)(1), added subsecs. (b) and (c).

Subsec. (d). Pub. L. 108–173, §921(e)(1), added subsec. (d).

Subsecs. (e) to (g). Pub. L. 108–173, §921(f)(1), added subsecs. (e) to (g).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §921(d)(2), Dec. 8, 2003, 117 Stat. 2391, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 2004.''

Pub. L. 108–173, title IX, §921(e)(2), Dec. 8, 2003, 117 Stat. 2391, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 2004.''

Pub. L. 108–173, title IX, §921(f)(2), Dec. 8, 2003, 117 Stat. 2392, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE

Pub. L. 108–173, title IX, §921(a)(2), Dec. 8, 2003, 117 Stat. 2388, provided that: ''The amendment made by paragraph (1) [enacting this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003].''

SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM

Pub. L. 108–173, title IX, §922, Dec. 8, 2003, 117 Stat. 2392, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a demonstration program (in this section referred to as the 'demonstration program') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (including provisions of title XI of such Act [42 U.S.C. 1301 et seq.] insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

''(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

''(A) evaluation and recommendations regarding billing and related systems; and

''(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

''(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term 'small providers of services or suppliers' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.

''(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review [now ''quality improvement''] organizations or entities described in section 1889(g)(2) of the Social Security Act [42 U.S.C. 1395zz(g)(2)], as inserted by section 921(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

''(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

''(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

''(e) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from amounts not otherwise appropriated in the Treasury, such sums as may be necessary to carry out this section.''

§ 1395aaa. Contract with a consensus-based entity regarding performance measurement

(a) Contract

(1) In general

For purposes of activities conducted under this chapter, the Secretary shall identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, that meets the requirements described in subsection (c). Such contract shall provide that the entity will perform the duties described in subsection (b).

(2) Timing for first contract

As soon as practicable after July 15, 2008, the Secretary shall enter into the first contract under paragraph (1).

(3) Period of contract

A contract under paragraph (1) shall be for a period of 4 years (except as may be renewed after a subsequent bidding process).

(4) Competitive procedures

Competitive procedures (as defined in section 132 of title 41) shall be used to enter into a contract under paragraph (1).

(b) Duties

The duties described in this subsection are the following:

(1) Priority setting process

The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this chapter, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall—

(A) ensure that priority is given to measures—

(i) that address the health care provided to patients with prevalent, high-cost chronic diseases;

(ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and

(iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and

(B) take into account measures that—

(i) may assist consumers and patients in making informed health care decisions;

(ii) address health disparities across groups and areas; and

(iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

(2) Endorsement of measures

The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, fea-

sible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and

(B) is consistent across types of health care providers, including hospitals and physicians.

(3) Maintenance of measures

The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed.

(4) Removal of measures

The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal.

(5) Annual report to Congress and the Secretary; secretarial publication and comment

(A)[1] Annual report

By not later than March 1 of each year (beginning with 2009), the entity shall submit to Congress and the Secretary a report containing the following:

(i) A description of—

(I) the implementation of quality measurement initiatives under this chapter and the coordination of such initiatives with quality initiatives implemented by other payers;

(II) the recommendations made under paragraph (1);

(III) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a);

(IV) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 280j of this title, and where quality measures are unavailable or inadequate to identify or address such gaps;

(V) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 280j of this title and where targeted research may address such gaps; and

(VI) the matters described in clauses (i) and (ii) of paragraph (7)(A).

(ii) An itemization of financial information for the fiscal year ending September 30 of the preceding year, including—

(I) annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue);

(II) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs); and

(III) a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity.

(iii) Any updates or modifications of internal policies and procedures of the entity as they relate to the duties of the entity under this section, including—

(I) specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity; and

(II) information on external stakeholder participation in the duties of the entity under this section (including complete rosters for all committees, work groups, task forces, and advisory panels funded through government contracts, descriptions of relevant interests and any conflicts of interest for members of all committees, work groups, task forces, and advisory panels, and the total percentage by health care sector of all convened committees, work groups, task forces, and advisory panels.[2]

(B) Secretarial review and publication of annual report

Not later than 6 months after receiving a report under subparagraph (A) for a year, the Secretary shall—

(i) review such report; and

(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.

(6) Review and endorsement of episode grouper under the physician feedback program

The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1395w–4(n)(9)(A) of this title. Such review shall be conducted on an expedited basis.

(7) Convening multi-stakeholder groups

(A) In general

The entity shall convene multi-stakeholder groups to provide input on—

(i) the selection of quality and efficiency measures described in subparagraph (B), from among—

(I) such measures that have been endorsed by the entity; and

(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and

(ii) national priorities (as identified under section 280j of this title) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 280j of this title.

(B) Quality and efficiency measures

(i) In general

Subject to clause (ii), the quality and efficiency measures described in this sub-

[1] See 2018 Amendment note below.

[2] So in original. Probably should be ''panels).''

paragraph are quality and efficiency measures—

(I) for use pursuant to sections 1395f(i)(5)(D), 1395*l*(i)(7), 1395*l*(t)(17), 1395w–4(k)(2)(C), 1395cc(k)(3), 1395rr(h)(2)(A)(iii),[3] 1395ww(b)(3)(B)(viii), 1395ww(j)(7)(D), 1395ww(m)(5)(D), 1395ww(*o*)(2), 1395ww(s)(4)(D), and 1395fff(b)(3)(B)(v) of this title;

(II) for use in reporting performance information to the public; and

(III) for use in health care programs other than for use under this chapter.

(ii) Exclusion

Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this subchapter shall not be quality and efficiency measures described in this subparagraph.

(C) Requirement for transparency in process

(i) In general

In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality and efficiency measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

(ii) Selection of organizations participating in multi-stakeholder groups

The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

(D) Multi-stakeholder group defined

In this paragraph, the term ''multi-stakeholder group'' means, with respect to a quality and efficiency measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality and efficiency measure.

(8) Transmission of multi-stakeholder input

Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).

(9) Prioritization of measure endorsement

The Secretary—

(A) during the period beginning on December 27, 2020, and ending on December 31, 2023, shall prioritize the endorsement of measures relating to maternal morbidity and mortality by the entity with a contract under subsection (a) in connection with endorsement of measures described in paragraph (2); and

(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.

[3] See References in Text note below.

(c) Requirements described

The requirements described in this subsection are the following:

(1) Private nonprofit

The entity is a private nonprofit entity governed by a board.

(2) Board membership

The members of the board of the entity include—

(A) representatives of health plans and health care providers and practitioners or representatives of groups representing such health plans and health care providers and practitioners;

(B) health care consumers or representatives of groups representing health care consumers; and

(C) representatives of purchasers and employers or representatives of groups representing purchasers or employers.

(3) Entity membership

The membership of the entity includes persons who have experience with—

(A) urban health care issues;

(B) safety net health care issues;

(C) rural and frontier health care issues; and

(D) health care quality and safety issues.

(4) Open and transparent

With respect to matters related to the contract with the Secretary under subsection (a), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment on its activities.

(5) Voluntary consensus standards setting organization

The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

(6) Experience

The entity has at least 4 years of experience in establishing national consensus standards.

(7) Membership fees

If the entity requires a membership fee for participation in the functions of the entity, such fees shall be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case shall membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

(d) Funding

(1) For purposes of carrying out this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in such proportion as the Secretary determines appropriate),

of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2009 through 2013. Amounts transferred under the preceding sentence shall remain available until expended.

(2) For purposes of carrying out this section and section 1395aaa–1 of this title (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of $5,000,000 for fiscal year 2014, $30,000,000 for each of fiscal years 2015 through 2017, $7,500,000 for each of fiscal years 2018 and 2019, $20,000,000 for fiscal year 2020, $26,000,000 for fiscal year 2021, $20,000,000 for fiscal year 2022, and $20,000,000 for fiscal year 2023. Amounts transferred under the preceding sentence shall remain available until expended. Amounts transferred for each of fiscal years 2018, 2019, 2020, 2021, 2022, and 2023, shall be in addition to any unobligated funds transferred for a preceding fiscal year that are available under the preceding sentence.

(e) Annual report by Secretary to Congress

(1) In general

By not later than March 1 of each year (beginning with 2019), the Secretary shall submit to Congress a report containing the following:

(A) A comprehensive plan that identifies the quality measurement needs of programs and initiatives of the Secretary and provides a strategy for using the entity with a contract under subsection (a) and any other entity the Secretary has contracted with or may contract with to perform work associated with section 1395aaa–1 of this title to help meet those needs, specifically with respect to the programs under this subchapter and subchapter XIX.

(B) The amount of funding provided under subsection (d) for purposes of carrying out this section and section 1395aaa–1 of this title that has been obligated by the Secretary, the amount of funding provided that has been expended, and the amount of funding provided that remains unobligated.

(C) With respect to the activities described under this section or section 1395aaa–1 of this title, a description of how the funds described in paragraph (2) have been obligated or expended, including how much of that funding has been obligated or expended for work performed by the Secretary, the entity with a contract under subsection (a), and any other entity the Secretary has contracted with to perform work.

(D) Subject to paragraph (2)(B), a description of the activities for which the funds described in paragraph (2) were used, including task orders and activities assigned to the entity with a contract under subsection (a), activities performed by the Secretary, and task orders and activities assigned to any other entity the Secretary has contracted with to perform work related to carrying out section 1395aaa–1 of this title.

(E) Subject to paragraph (2)(B), the amount of funding described in paragraph (2) that has been obligated or expended for each of the activities described in paragraph (4).

(F) Subject to paragraph (2)(B), estimates for, and descriptions of, obligations and expenditures that the Secretary anticipates will be needed in the succeeding two year period to carry out each of the quality measurement activities required under this section and section 1395aaa–1 of this title, including any obligations that will require funds to be expended in a future year.

(2) Additional requirements for reports

(A) Addressing GAO report

Each of the annual reports submitted in 2021 and 2022 pursuant to paragraph (1) shall also include the following:

(i) A comprehensive analysis detailing the ways in which the Centers for Medicare & Medicaid Services has addressed each of the recommendations set forth in the report by the Government Accountability Office (GAO–19–628) issued on September 19, 2019, and titled ''Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives''.

(ii) A detailed description of—

(I) any additional steps that the Centers for Medicare & Medicaid Services expects to take to address the findings and recommendations set forth in such report; and

(II) the anticipated timing for such steps.

(B) Ensuring detailed information

(i) In general

In the case of an annual report submitted in 2021 or a subsequent year pursuant to paragraph (1), the information required under—

(I) paragraph (1)(D) shall also include detailed information on each of the activities described in clause (ii);

(II) paragraph (1)(E) shall also include detailed information on the specific amounts obligated or expended on each of the activities described in clause (ii); and

(III) paragraph (1)(F) shall also include detailed information on the specific quality measurement activities required and future funding needed for each of the activities described in clause (ii).

(ii) Activities described

The activities described in this clause are the following:

(I) Measure selection activities.

(II) Measure development activities.

(III) Public reporting activities.

(IV) Education and outreach activities.

(f) Additional reporting by the Secretary to Congress

(1) In general

By not later than September 30 of each year (beginning with 2021), the Secretary shall sub-

mit to Congress a report on the amount of unobligated balances for appropriations relating to quality measurement. Such report shall include detailed plans on how the Secretary expects to expend such unobligated balances in the upcoming fiscal years.

(2) Separate report

The annual report required under paragraph (1) shall be separate from the annual report required under subsection (e).

(Aug. 14, 1935, ch. 531, title XVIII, § 1890, as added Pub. L. 110–275, title I, § 183(a)(1), July 15, 2008, 122 Stat. 2583; amended Pub. L. 111–148, title III, §§ 3003(b), 3014(a), title X, §§ 10304, 10322(b), Mar. 23, 2010, 124 Stat. 367, 384, 938, 954; Pub. L. 112–240, title VI, § 609(a), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, § 1109, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, § 109, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, § 207, Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E, title II, § 50206(a)–(c)(1), Feb. 9, 2018, 132 Stat. 183–185; Pub. L. 116–59, div. B, title IV, § 1401, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title IV, § 1401(a), Nov. 21, 2019, 133 Stat. 1138; Pub. L. 116–94, div. N, title I, § 102(a), Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, § 3802(a), Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–159, div. C, title II, § 2202, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, § 1103, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. CC, title I, § 102, Dec. 27, 2020, 134 Stat. 2940.)

Editorial Notes

REFERENCES IN TEXT

Clause (iii) of section 1395rr(h)(2)(A) of this title, referred to in subsec. (b)(7)(B)(i)(I), was redesignated clause (iv) by Pub. L. 113–93, title II, § 217(d)(1)(B), Apr. 1, 2014, 128 Stat. 1062.

Section 12(d) of the National Technology Transfer and Advancement Act of 1995, referred to in subsec. (c)(5), is section 12(d) of Pub. L. 104–113, which is set out as a note under section 272 of Title 15, Commerce and Trade.

CODIFICATION

In subsec. (a)(4), ''section 132 of title 41'' substituted for ''section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))'' on authority of Pub. L. 111–350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1395aaa, act Aug. 14, 1935, ch. 531, title XVIII, § 1890, as added Aug. 18, 1987, Pub. L. 100–93, § 10, 101 Stat. 696, which related to limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities, was amended and transferred to section 1862(e)(2) of act Aug. 14, 1935, by Pub. L. 100–360, title IV, § 411(i)(4)(D)(ii), July 1, 1988, 102 Stat. 790, as amended by Pub. L. 100–485, title VI, § 608(d)(24)(C)(ii), Oct. 13, 1988, 102 Stat. 2421, and is classified to section 1395y(e)(2) of this title.

AMENDMENTS

2020—Subsec. (b)(4). Pub. L. 116–260, § 102(c), added par. (4).

Subsec. (b)(9). Pub. L. 116–260, § 102(d), added par. (9).

Subsec. (d)(2). Pub. L. 116–260, § 102(a), substituted ''$26,000,000 for fiscal year 2021, $20,000,000 for fiscal year 2022, and $20,000,000 for fiscal year 2023'' for ''and for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020'' in first sentence and ''2020, 2021, 2022, and 2023'' for ''and 2020, and for the period beginning on October 1, 2020, and ending on December 18, 2020'' in last sentence.

Pub. L. 116–215 substituted ''December 18, 2020'' for ''December 11, 2020'' in two places.

Pub. L. 116–159 substituted ''December 11, 2020'' for ''November 30, 2020'' in two places.

Pub. L. 116–136, § 3802, substituted ''$20,000,000 for fiscal year 2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020'' for ''and $4,830,000 for the period beginning on October 1, 2019, and ending on May 22, 2020'' in first sentence and '', 2019, and 2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020,'' for ''and 2019 and for the period beginning on October 1, 2019, and ending on May 22, 2020'' in last sentence.

Subsec. (e). Pub. L. 116–260, § 102(b)(1)(A), (B), (G), designated existing provisions as par. (1), inserted heading, redesignated former pars. (1) to (6) as subpars. (A) to (F), respectively, of par. (1), and added par. (2).

Subsec. (e)(1)(A). Pub. L. 116–260, § 102(b)(1)(C), struck out at end ''In years after the first plan under this paragraph is submitted, the requirements of this paragraph may be met by providing an update to the plan.''

Subsec. (e)(1)(D). Pub. L. 116–260, § 102(b)(1)(D), substituted ''Subject to paragraph (2)(B), a description'' for ''A description''.

Subsec. (e)(1)(E). Pub. L. 116–260, § 102(b)(1)(E), substituted ''Subject to paragraph (2)(B), the amount'' for ''The amount''.

Subsec. (e)(1)(F). Pub. L. 116–260, § 102(b)(1)(F), substituted ''Subject to paragraph (2)(B), estimates'' for ''Estimates''.

Subsec. (f). Pub. L. 116–260, § 102(b)(2), added subsec. (f).

2019—Subsec. (d)(2). Pub. L. 116–94 substituted ''$4,830,000 for the period beginning on October 1, 2019, and ending on May 22, 2020'' for ''$1,665,000 for the period beginning on October 1, 2019, and ending on December 20, 2019'' in first sentence and ''May 22, 2020'' for ''December 20, 2019,'' in last sentence.

Pub. L. 116–69 substituted ''$1,665,000 for the period beginning on October 1, 2019, and ending on December 20, 2019'' for ''$1,069,000 for the period beginning on October 1, 2019, and ending on November 21, 2019'' in first sentence and ''December 20, 2019'' for ''November 21, 2019'' in last sentence.

Pub. L. 116–59 substituted ''$7,500,000 for each of fiscal years 2018 and 2019, and $1,069,000 for the period beginning on October 1, 2019, and ending on November 21, 2019'' for ''and $7,500,000 for each of fiscal years 2018 and 2019'' in first sentence and inserted ''and for the period beginning on October 1, 2019, and ending on November 21, 2019,'' after ''2018 and 2019'' in last sentence.

2018—Subsec. (b)(5)(A). Pub. L. 115–123, § 50206(c)(1), substituted ''containing the following:'' for ''containing a description of—'' in introductory provisions, inserted ''(i) A description of—'', redesignated former cls. (i) to (vi) as subcls. (I) to (VI), respectively, of cl. (i), realigned margins, and added cls. (ii) and (iii).

Subsec. (d)(2). Pub. L. 115–123, § 50206(a), substituted ''2014,'' for ''2014 and'' and inserted '', and $7,500,000 for each of fiscal years 2018 and 2019'' after ''through 2017'' and ''Amounts transferred for each of fiscal years 2018 and 2019 shall be in addition to any unobligated funds transferred for a preceding fiscal year that are available under the preceding sentence.'' after ''until expended.''

Subsec. (e). Pub. L. 115–123, § 50206(b), added subsec. (e).

2015—Subsec. (d)(2). Pub. L. 114–10 substituted ''and $30,000,000 for each of fiscal years 2015 through 2017'' for ''and $15,000,000 for the first 6 months of fiscal year 2015''.

2014—Subsec. (d). Pub. L. 113–93 designated existing provisions as par. (1) and added par. (2).

2013—Subsec. (b)(4). Pub. L. 112–240, §609(a)(2), struck out par. (4). Text read as follows: ''The entity shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.''

Subsec. (d). Pub. L. 113–67 inserted at end ''Amounts transferred under the preceding sentence shall remain available until expended.''

Pub. L. 112–240, §609(a)(1), substituted ''fiscal years 2009 through 2013'' for ''fiscal years 2009 through 2012''.

2010—Subsec. (b)(5)(A)(iv) to (vi). Pub. L. 111–148, §3014(a)(2), added cls. (iv) to (vi).

Subsec. (b)(6). Pub. L. 111–148, §3003(b), added par. (6).

Subsec. (b)(7). Pub. L. 111–148, §10304, substituted ''quality and efficiency'' for ''quality'' wherever appearing in text.

Pub. L. 111–148, §3014(a)(1), added par. (7).

Subsec. (b)(7)(B). Pub. L. 111–148, §10304, which directed substitution of ''quality and efficiency'' for ''quality'' wherever appearing, was executed by substituting ''Quality and efficiency'' for ''Quality'' in subpar. heading to reflect the probable intent of Congress.

Subsec. (b)(7)(B)(i)(I). Pub. L. 111–148, §10322(b), inserted ''1395ww(s)(4)(D),'' after ''1395ww(*o*)(2),''.

Subsec. (b)(8). Pub. L. 111–148, §3014(a)(1), added par. (8).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3802(b), Mar. 27, 2020, 134 Stat. 427, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Further Consolidated Appropriations Act, 2020 (Public Law 116–94).''

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §102(b), Dec. 20, 2019, 133 Stat. 3096, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (Public Law 116–69).''

Pub. L. 116–69, div. B, title IV, §1401(b), Nov. 21, 2019, 133 Stat. 1138, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (Public Law 116–59).''

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title II, §50206(c)(2), Feb. 9, 2018, 132 Stat. 185, provided that: ''The amendments made by this subsection [amending this section] shall apply to reports submitted for years beginning with 2019.''

§ 1395aaa–1. Quality and efficiency measurement

(a) Multi-stakeholder group input into selection of quality and efficiency measures

The Secretary shall establish a pre-rule-making process under which the following steps occur with respect to the selection of quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title:

(1) Input

Pursuant to section 1395aaa(b)(7) of this title, the entity with a contract under section 1395aaa of this title shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures described in subparagraph (B) of such paragraph.

(2) Public availability of measures considered for selection

Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title that the Secretary is considering under this subchapter.

(3) Transmission of multi-stakeholder input

Pursuant to section 1395aaa(b)(8) of this title, not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

(4) Consideration of multi-stakeholder input

The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title that have been endorsed by the entity with a contract under section 1395aaa of this title and measures that have not been endorsed by such entity.

(5) Rationale for use of quality and efficiency measures

The Secretary shall publish in the Federal Register the rationale for the use of any quality and efficiency measure described in section 1395aaa(b)(7)(B) of this title that has not been endorsed by the entity with a contract under section 1395aaa of this title.

(6) Assessment of impact

Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

(A) conduct an assessment of the quality and efficiency impact of the use of endorsed measures described in section 1395aaa(b)(7)(B) of this title; and

(B) make such assessment available to the public.

(b) Process for dissemination of measures used by the Secretary

(1) In general

The Secretary shall establish a process for disseminating quality and efficiency measures used by the Secretary. Such process shall include the following:

(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

(B) The dissemination of such quality and efficiency measures through the national strategy developed under section 280j of this title.

(2) Existing methods

To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality and efficiency measures under the process established under paragraph (1).

(c) Review of quality and efficiency measures used by the Secretary

(1) In general

The Secretary shall—

(A) periodically (but in no case less often than once every 3 years) review quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title; and

(B) with respect to each such measure, determine whether to—

(i) maintain the use of such measure; or

(ii) phase out such measure.

(2) Considerations

In conducting the review under paragraph (1), the Secretary shall take steps to—

(A) seek to avoid duplication of measures used; and

(B) take into consideration current innovative methodologies and strategies for quality and efficiency improvement practices in the delivery of health care services that represent best practices for such quality and efficiency improvement and measures endorsed by the entity with a contract under section 1395aaa of this title since the previous review by the Secretary.

(d) Rule of construction

Nothing in this section shall preclude a State from using the quality and efficiency measures identified under sections 1320b–9a and 1320b–9b of this title.

(e) Development of quality and efficiency measures

The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality and efficiency measures (as determined appropriate by the Administrator) for use under this chapter. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.

(f) Hospital acquired conditions

The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.

(g) Technical expert panel review of opioid and opioid use disorder quality measures

(1) In general

Not later than 180 days after October 24, 2018, the Secretary shall establish a technical expert panel for purposes of reviewing quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1395aaa(a) of this title and amend such contract as necessary to provide for the establishment of such technical expert panel.

(2) Review and assessment

Not later than 1 year after the date the technical expert panel described in paragraph (1) is established (and periodically thereafter as the Secretary determines appropriate), the technical expert panel shall—

(A) review quality measures that relate to opioids and opioid use disorders, including existing measures and those under development;

(B) identify gaps in areas of quality measurement that relate to opioids and opioid use disorders, and identify measure development priorities for such measure gaps; and

(C) make recommendations to the Secretary on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such measures in the Merit-Based Incentive Payment System under section 1395w–4(q) of this title, the alternative payment models under section 1395*l*(z)(3)(C) of this title, the shared savings program under section 1395jjj of this title, the quality reporting requirements for inpatient hospitals under section 1395ww(b)(3)(B)(viii) of this title, and the hospital value-based purchasing program under section 1395ww(*o*) of this title.

(3) Consideration of measures by Secretary

The Secretary shall consider—

(A) using opioid and opioid use disorder measures (including measures used under the Merit-Based Incentive Payment System under section 1395w–4(q) of this title, measures recommended under paragraph (2)(C), and other such measures identified by the Secretary) in alternative payment models under section 1395*l*(z)(3)(C) of this title and in the shared savings program under section 1395jjj of this title; and

(B) using opioid measures described in subparagraph (A), as applicable, in the quality reporting requirements for inpatient hospitals under section 1395ww(b)(3)(B)(viii) of this title, and in the hospital value-based purchasing program under section 1395ww(*o*) of this title.

(4) Prioritization of measure development

The Secretary shall prioritize for measure development the gaps in quality measures identified under paragraph (2)(B).

(5) Prioritization of measure endorsement

The Secretary—

(A) during the period beginning on October 24, 2018, and ending on December 31, 2023, shall prioritize the endorsement of measures relating to opioids and opioid use disorders by the entity with a contract under subsection (a) of section 1395aaa of this title in connection with endorsement of measures described in subsection (b)(2) of such section; and

(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.

(Aug. 14, 1935, ch. 531, title XVIII, § 1890A, as added and amended Pub. L. 111–148, title III, §§ 3013(b), 3014(b), title X, §§ 10303(b), 10304, Mar. 23, 2010, 124 Stat. 383, 385, 938; Pub. L. 115–271, title VI, § 6093, Oct. 24, 2018, 132 Stat. 4001.)

Editorial Notes

AMENDMENTS

2018—Subsec. (g). Pub. L. 115–271 added subsec. (g).

2010—Pub. L. 111–148, § 10304, substituted ''quality and efficiency'' for ''quality'' wherever appearing in text.

Subsec. (e). Pub. L. 111–148, § 3013(b), added subsec. (e).

Subsec. (f). Pub. L. 111–148, § 10303(b), added subsec. (f).

§ 1395bbb. Conditions of participation for home health agencies; home health quality

(a) Conditions of participation; protection of individual rights; notification of State entities; use of home health aides; medical equipment; individual's plan of care; compliance with Federal, State, and local laws and regulations

The conditions of participation that a home health agency is required to meet under this subsection are as follows:

(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

(C) The right to confidentiality of the clinical records described in section 1395x(*o*)(3) of this title.

(D) The right to have one's property treated with respect.

(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this subchapter,

(ii) the coverage available for such items and services under this subchapter, subchapter XIX, and any other Federal program of which the agency is reasonably aware,

(iii) any charges for items and services not covered under this subchapter and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

(F) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this subchapter.

(G) The right to be informed of the availability of the State home health agency hotline established under section 1395aa(a) of this title.

(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

(A) the persons with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the agency,

(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a–5(b) of this title) of the agency, and

(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual to provide items or services described in section 1395x(m) of this title on or after January 1, 1990, unless the individual—

(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1395x(m) of this title for compensation.

(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1989, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

(ii) The agency must provide such regular performance review and regular in-service education as assures that individuals used to provide items and services described in section 1395x(m) of this title are competent to provide those items and services.

(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on December 22, 1987; except that they

may not provide for the approval of a program offered by or in a home health agency which, within the previous 2 years—

(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than $5,000; or

(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).

(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1989) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

(E) In this paragraph, the term ''home health aide'' means any individual who provides the items and services described in section 1395x(m) of this title, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (F)), or

(ii) who volunteers to provide such services without monetary compensation.

(F) In this paragraph, the term ''licensed health professional'' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(4) The agency includes an individual's plan of care required under section 1395x(m) of this title as part of the clinical records described in section 1395x(*o*)(3) of this title.

(5) The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

(6) The agency complies with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(b) Duty of Secretary

It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1395x(*o*) of this title and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.

(c) Surveys of home health agencies

(1) Any agreement entered into or renewed by the Secretary pursuant to section 1395aa of this title relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a of this title. The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.

(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—

(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1395aa(a) of this title), or any other appropriate Federal, State, or local agency.

(C) A standard survey conducted under this paragraph with respect to a home health agency—

(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d)) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1395x(m) of this title and clinical records required under section 1395x(*o*)(3) of this title; and

(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1395x(*o*) of this title or subsection (a) of this section, and

(III) who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1395x(*o*) of this title or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) on the basis of the findings of a standard survey.

(d) Assessment process; reports to Congress

(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(i)(I).

(2)(A) Not later than January 1, 1992, the Secretary shall—

(i) evaluate the assessment process,

(ii) report to Congress on the results of such evaluation, and

(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).

(e) Enforcement

(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter is no longer in compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a) and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A).

(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter is no longer in compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a) and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f), in lieu of terminating the certification of the agency. If, after such a period of intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a), the Secretary shall terminate the certification of the agency.

(3) If the Secretary determines that a home health agency that is certified for participation under this subchapter is in compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a) but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection (f)(2)(A)(i) for the days in which it finds that the agency was not in compliance with such requirements.

(4) The Secretary may continue payments under this subchapter with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a) over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the agency with the requirements than to terminate the certification of the agency,

(B) the agency has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the agency agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by home health agencies under this subparagraph.

(f) Intermediate sanctions

(1) The Secretary shall develop and implement, by not later than April 1, 1989—

(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance,

(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this subchapter with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2), and

(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a).

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1395x(*o*) of this title and subsection (a).

(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(g) Payment on basis of location of service

A home health agency shall submit claims for payment for home health services under this subchapter only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, § 1891, as added and amended Pub. L. 100–203, title IV, §§ 4021(b), 4022(a), 4023(a), Dec. 22, 1987, 101 Stat. 1330–67, 1330–69, 1330–71; Pub. L. 100–360, title IV, § 411(d)(1)(A), (2)–(3)(B), July 1, 1988, 102 Stat. 773, 774; Pub. L. 100–485, title VI, § 608(d)(20)(A), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–508, title IV, §§ 4206(d)(2), 4207(i)(1), formerly 4027(i)(1), Nov. 5, 1990, 104 Stat. 1388–116, 1388–123, renumbered Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–134, title I, § 101(d) [title V, § 516(a)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–246; renumbered title I, Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 105–33, title IV, § 4604(a), Aug. 5, 1997, 111 Stat. 472; Pub. L. 108–173, title VII, § 736(c)(3), Dec. 8, 2003, 117 Stat. 2356.)

Editorial Notes

AMENDMENTS

2003—Subsec. (d)(1). Pub. L. 108–173 substituted ''subsection (c)(2)(C)(i)(I)'' for ''subsection (c)(2)(C)(I)''.

1997—Subsec. (g). Pub. L. 105–33 added subsec. (g).

1996—Subsec. (c)(2)(A). Pub. L. 104–134 substituted ''36 months'' for ''15 months'' in first sentence and amended last sentence generally. Prior to amendment, last sentence read as follows: ''The statewide average interval between standard surveys of any home health agency shall not exceed 12 months.''

1990—Subsec. (a)(3)(D)(iii). Pub. L. 101–508, § 4207(i)(1), formerly § 4027(i)(1), as renumbered by Pub. L. 103–432, substituted ''which, within the previous 2 years—'' and subcls. (I) to (IV) for ''which has been determined to be out of compliance with the requirements specified in or pursuant to section 1395x(*o*) of this title or subsection (a) of this section within the previous 2 years.''

Subsec. (a)(6). Pub. L. 101–508, § 4206(d)(2), added par. (6).

1988—Subsec. (a)(3)(A). Pub. L. 100–360, § 411(d)(1)(A)(i), struck out ''who is not a licensed health care professional (as defined in subparagraph (F))'' after ''any individual'' in introductory provisions.

Subsec. (a)(3)(F). Pub. L. 100–360, § 411(d)(1)(A)(ii), inserted ''physical or occupational therapy assistant,'' after ''occupational therapist''.

Subsec. (a)(4) to (6). Pub. L. 100–360, § 411(d)(1)(A)(iii), redesignated pars. (5) and (6) as (4) and (5), respectively, and struck out former par. (4) which read as follows: ''With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment do not use (on a full-time, temporary, per diem, or other basis) any individual who does not meet minimum training standards (established by the Secretary by October 1, 1988) for the demonstration and use of any such equipment furnished to individuals with respect to whom payments may be made under this subchapter.''

Subsec. (c)(1). Pub. L. 100–360, § 411(d)(2)(A), as amended by Pub. L. 100–485, § 608(d)(20)(A), amended third sentence generally. Prior to amendment, third sentence read as follows: ''The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title.''

Subsec. (d)(2)(A). Pub. L. 100–360, § 411(d)(2)(B), substituted ''1992'' for ''1991'' in introductory provisions.

Subsecs. (e), (f). Pub. L. 100–360, § 411(d)(3)(A), made technical amendment to Pub. L. 100–203, § 4023(a), see 1987 Amendment note below.

Subsec. (f)(2)(A). Pub. L. 100–360, § 411(d)(3)(B)(iii), inserted before last sentence ''The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.''

Pub. L. 100–360, § 411(d)(3)(B)(i), realigned the margins of cls. (i) to (iii) and concluding provisions.

Subsec. (f)(2)(A)(i). Pub. L. 100–360, § 411(d)(3)(B)(ii), substituted ''in an amount not to exceed $10,000 for

each day of noncompliance'' for ''for each day of noncompliance''.

1987—Subsecs. (c), (d). Pub. L. 100–203, § 4022(a), added subsecs. (c) and (d).

Subsecs. (e), (f). Pub. L. 100–203, § 4023(a), as amended by Pub. L. 100–360, § 411(d)(3)(A), added subsecs. (e) and (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1997, see section 4604(c) of Pub. L. 105–33, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4206(d)(2) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(1) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

Pub. L. 101–508, title IV, § 4207(i)(1), formerly § 4027(i)(1), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that the amendment made by that section is effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.

Pub. L. 101–508, title IV, § 4207(i)(2), formerly § 4027(i)(2), Nov. 5, 1990, 104 Stat. 1388–124, as renumbered and amended by Pub. L. 103–432, title I, § 160(d)(4), (11), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that the Secretary may not permit approval of a training and competency evaluation program or a competency evaluation program offered by or in a home health agency which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

''(i) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.];

''(ii) was assessed a civil money penalty not less than $5,000 for deficiencies in applicable quality standards for home health agencies;

''(iii) was subject to suspension by the Secretary of all or part of the payments to which it would otherwise be entitled under such title;

''(iv) operated under a temporary management appointed to oversee the operation of the agency and to ensure the health and safety of the agency's patients; or

''(v) pursuant to State action, was closed or had its patients transferred.''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4022(b), Dec. 22, 1987, 101 Stat. 1330–71, provided that: ''Except as otherwise specifically provided in section 1891(d) of the Social Security Act [42 U.S.C. 1395bbb(d)] (as added by subsection (a)), the amendment made by subsection (a) [amending this section] shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987].''

Pub. L. 100–203, title IV, § 4023(b), Dec. 22, 1987, 101 Stat. 1330–73, as amended by Pub. L. 100–360, title IV, § 411(d)(3)(C), July 1, 1988, 102 Stat. 774, provided that: ''Except as otherwise specifically provided in subsections (e) and (f) of section 1891 of the Social Security Act [42 U.S.C. 1395bbb(e), (f)] (as added by subsection (a)), the amendment made by subsection (a) [amending this section] shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987], and no intermediate sanction described in section 1891(f)(2)(A) of such Act [42 U.S.C. 1395bbb(f)(2)(A)] shall be imposed for violations occurring before such effective date.''

EFFECTIVE DATE

Section applicable to home health agencies as of the first day of the 18th calendar month that begins after Dec. 22, 1987, except as otherwise provided, see section 4021(c) of Pub. L. 100–203, set out as an Effective Date of 1987 Amendment note under section 1395x of this title.

TREATMENT OF BRANCH OFFICES; GAO STUDY ON SUPERVISION OF HOME HEALTH CARE PROVIDED IN ISOLATED RURAL AREAS

Pub. L. 106–554, § 1(a)(6) [title V, § 506], Dec. 21, 2000, 114 Stat. 2763, 2763A–531, provided that:

''(a) TREATMENT OF BRANCH OFFICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, in determining for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] whether an office of a home health agency constitutes a branch office or a separate home health agency, neither the time nor distance between a parent office of the home health agency and a branch office shall be the sole determinant of a home health agency's branch office status.

''(2) CONSIDERATION OF FORMS OF TECHNOLOGY IN DEFINITION OF SUPERVISION.—The Secretary of Health and Human Services may include forms of technology in determining what constitutes 'supervision' for purposes of determining a home heath [sic] agency's branch office status under paragraph (1).

''(b) GAO STUDY.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study of the provision of adequate supervision to maintain quality of home health services delivered under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in isolated rural areas. The study shall evaluate the methods that home health agency branches and subunits use to maintain adequate supervision in the delivery of services to clients residing in those areas, how these methods of supervision compare to requirements that subunits independently meet medicare conditions of participation, and the resources utilized by subunits to meet such conditions.

''(2) REPORT.—Not later than January 1, 2002, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations on whether exceptions are needed for subunits and branches of home health agencies under the medicare program to maintain access to the home health benefit or whether alternative policies should be developed to assure adequate supervision and access and recommendations on whether a national standard for supervision is appropriate.''

§ 1395ccc. Offset of payments to individuals to collect past-due obligations arising from breach of scholarship and loan contract

(a) In general

(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this

section with any individual who, by reason of a breach of a contract entered into by such individual pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program, owes a past-due obligation to the United States (as defined in subsection (b)).

(B) The Secretary shall not enter into an agreement with an individual under this section to the extent—

(i)(I) the individual has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987, and

(II) the individual has fulfilled or (as determined by the Secretary) is fulfilling the terms of such contract; or

(ii) the liability of the individual under such section 204(a)(1) has otherwise been relieved under such section; or

(iii) the individual is performing such physician's[1] service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act [42 U.S.C. 254d et seq.].

(2) The agreement under this section shall provide that—

(A) deductions shall be made from the amounts otherwise payable to the individual under this subchapter, in accordance with a formula and schedule agreed to by the Secretary and the individual, until such past-due obligation (and accrued interest) have been repaid;

(B) payment under this subchapter for services provided by such individual shall be made only on an assignment-related basis;

(C) if the individual does not provide services, for which payment would otherwise be made under this subchapter, of a sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(ii) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(3) If the individual refuses to enter into an agreement or breaches any provision of the agreement—

(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(B) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(4) The Secretary shall not exclude an individual pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such individual is a sole community practitioner or sole source of essential specialized services in a community if a State requests that the individual not be excluded.

(b) Past-due obligation

For purposes of this section, a past-due obligation is any amount—

(1) owed by an individual to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act [42 U.S.C. 254*o*] or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section, and has not been canceled, waived, or suspended by the Secretary pursuant to such section; or

(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I[2] of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.

(c) Collection under this section shall not be exclusive

This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31 and the application of other procedures provided under chapter 37 of title 31.

(d) Collection from providers and health maintenance organizations

(1) In the case of an individual who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1395cc of this title or a health maintenance organization or competitive medical plan having a contract under section 1395*l* of this title or section 1395mm of this title, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this subchapter to such provider, organization, or plan.

(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the individual and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the individual under this subchapter as long as the individual continues to be employed or affiliated by a medical services agreement.

(3) Such deduction shall not be made until 6 months after the Secretary notifies the provider, organization, or plan of the amount to be deducted and the particular physicians[3] to whom the deductions are attributable.

(4) A deduction made under this subsection shall relieve the individual of the obligation (to the extent of the amount collected) to the

[1] So in original. Probably should be ''individual's''.

[2] See References in Text note below.

[3] So in original. Probably should be ''individuals''.

United States, but the provider, organization, or plan shall have a right of action to collect from such individual the amount deducted pursuant to this subsection (including accumulated interest).

(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the individual pays the past-due obligation, or ceases to be employed by the provider, organization, or plan.

(6) The Secretary shall also apply the provisions of this subsection in the case of an individual who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.[3]

(e) Transfer from trust funds

Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.

(Aug. 14, 1935, ch. 531, title XVIII, § 1892, as added Pub. L. 100–203, title IV, § 4052(a), Dec. 22, 1987, 101 Stat. 1330–95; amended Pub. L. 100–360, title IV, § 411(f)(10)(A), (C)(i), July 1, 1988, 102 Stat. 780; Pub. L. 100–485, title VI, § 608(d)(21)(E)–(H), Oct. 13, 1988, 102 Stat. 2420.)

Editorial Notes

REFERENCES IN TEXT

Section 204(a)(1) of the Public Health Service Amendments of 1987, referred to in subsec. (a)(1)(B), is section 204(a)(1) of Pub. L. 100–177, title II, Dec. 1, 1987, 101 Stat. 1000, which is set out as a note under section 254*o* of this title.

The Public Health Service Act, referred to in subsecs. (a)(1)(B)(iii) and (b), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Subpart II of part D of title III of the Act is classified generally to subpart II (§ 254d et seq.) of part D of subchapter II of chapter 6A of this title. Subpart I of part C of title VII of the Act was classified generally to subpart I (§ 294 et seq.) of part C of subchapter V of chapter 6A of this title and was omitted in the general revision of subchapter V by Pub. L. 102–408, title I, § 102, Oct. 13, 1992, 106 Stat. 1994. See subpart I (§ 292 et seq.) of part A of subchapter V of chapter 6A of this title. Subpart III of part F of title VII of the Public Health Service Act (as in effect before October 1, 1976) was classified to subpart III (§ 295g–21 et seq.) of part F of subchapter V of chapter 6A of this title, prior to repeal by Pub. L. 94–484, title IV, § 409(a), Oct. 12, 1976, 90 Stat. 2290. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

1988—Pub. L. 100–360, § 411(f)(10)(C)(i)(I), substituted ''individuals'' for ''physicians'' and inserted ''and loan'' in section catchline.

Subsec. (a)(1)(A). Pub. L. 100–360, § 411(f)(10)(C)(i)(IV), as amended by Pub. L. 100–485, § 608(d)(21)(H), inserted '', the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in two places.

Subsec. (a)(1)(B). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician'' in introductory provisions and ''individual'' for ''physician'' in cls. (i)(I) and (II), (ii), and (iii).

Subsec. (a)(2)(A) to (C). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' wherever appearing.

Subsec. (a)(2)(C)(ii). Pub. L. 100–360, § 411(f)(10)(A)(i), substituted ''paragraph (4)'' for ''paragraph (3)''.

Subsec. (a)(3). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in introductory provisions.

Subsec. (a)(3)(B). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician''.

Pub. L. 100–360, § 411(f)(10)(A)(i), substituted ''paragraph (4)'' for ''paragraph (3)''.

Subsec. (a)(4). Pub. L. 100–360, § 411(f)(10)(C)(i)(III), substituted ''community practitioner'' for ''community physician''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician'' and ''such individual'' for ''such physician''.

Pub. L. 100–360, § 411(f)(10)(A)(iii), as amended by Pub. L. 100–360, § 608(d)(21)(E), inserted before period at end ''if a State requests that the individual not be excluded''.

Pub. L. 100–360, § 411(f)(10)(A)(ii), substituted ''exclude'' for ''bar''.

Subsec. (b). Pub. L. 100–360, § 411(f)(10)(C)(i)(V), as amended by Pub. L. 100–485, § 608(d)(21)(F)(i), substituted ''or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section'' for '', and (2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act''.

Subsec. (b)(1). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician''.

Subsec. (b)(2). Pub. L. 100–360, § 411(f)(10)(C)(i)(VI), as amended by Pub. L. 100–485, § 608(d)(21)(F)(i), added par. (2).

Subsec. (d)(1). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician''.

Subsec. (d)(2). Pub. L. 100–360, § 411(f)(10)(C)(i)(VII), as added by Pub. L. 100–485, § 608(d)(21)(F), substituted ''continues'' for ''continued''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in three places.

Subsec. (d)(4) to (6). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' wherever appearing.

Subsec. (e). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in two places.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(10)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, § 411(f)(10)(C)(iii), July 1, 1988, 102 Stat. 781, provided that: ''The Amendments made by this subparagraph [amending this section and former section 294f of this title] shall be effective 30 days after the date of the enactment of this Act [July 1, 1988].''

EFFECTIVE DATE

Pub. L. 100–203, title IV, § 4052(c), Dec. 22, 1987, 101 Stat. 1330–97, provided that: ''The amendments made by this section [enacting this section and amending section 254*o* of this title] shall be effective on the date of the enactment of this Act [Dec. 22, 1987].''

§ 1395ddd. Medicare Integrity Program

(a) Establishment of Program

There is hereby established the Medicare Integrity Program (in this section referred to as the ''Program'') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1395m(a)(15) of this title which are subject to prior authorization under such section.

(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).

(c) Eligibility of entities

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and

(5) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1395u of this title.

(d) Process for entering into contracts

The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1395h of this title or contracts under section 1395u of this title in effect on August 21, 1996.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

(f) Recovery of overpayments

(1) Use of repayment plans

(A) In general

If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this subchapter would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) Hardship

(i) In general

For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services or supplier for the previous calendar year.

(ii) Rule of application

The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this subchapter during the previous year or was paid under this subchapter only during a portion of that year.

(iii) Treatment of previous overpayments

If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) Exceptions

Subparagraph (A) shall not apply if—

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this subchapter; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) Immediate collection if violation of repayment plan

If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) Relation to no fault provision

Nothing in this paragraph shall be construed as affecting the application of section 1395gg(c) of this title (relating to no adjustment in the cases of certain overpayments).

(2) Limitation on recoupment

(A) In general

In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under section 1395ff(b)(1) of this title, the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) Collection with interest

Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) Medicare contractor defined

For purposes of this subsection, the term ''medicare contractor'' has the meaning given such term in section 1395zz(g) of this title.

(3) Limitation on use of extrapolation

A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4) Provision of supporting documentation

In the case of a provider of services or supplier with respect to which amounts were pre-

viously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) Consent settlement reforms

(A) In general

The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) Opportunity to submit additional information before consent settlement offer

Before offering a provider of services or supplier a consent settlement, the Secretary shall—

(i) communicate to the provider of services or supplier—

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) Consent settlement offer

The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) Consent settlement defined

For purposes of this paragraph, the term ''consent settlement'' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) Notice of over-utilization of codes

The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this subchapter (or provisions of subchapter XI insofar as they relate to such programs).

(7) Payment audits

(A) Written notice for post-payment audits

Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this subchapter, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) Explanation of findings for all audits

Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this subchapter, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this subchapter as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) Exception

Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(8) Standard methodology for probe sampling

The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

(g) Medicare-Medicaid Data Match Program

(1) Expansion of Program

(A) In general

The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the ''Medi-Medi Program'') is conducted with respect to the program established under this subchapter and State Medicaid programs under subchapter XIX for the purpose of—

(i) identifying program vulnerabilities in the program established under this sub-

chapter and the Medicaid program established under subchapter XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under subchapter XIX, as well as the program established under this subchapter;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture—

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements

The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1396b(q) of this title). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority

The Secretary shall waive only such requirements of this section and of subchapters XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for States

The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

(h) Use of recovery audit contractors

(1) In general

Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this subchapter with respect to all services for which payment is made under this subchapter. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment—

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) Disposition of remaining recoveries

The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) or paragraph (10) shall be applied to reduce expenditures under this subchapter.

(3) Nationwide coverage

The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) Audit and recovery periods

Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this subchapter—

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) Waiver

The Secretary shall waive such provisions of this subchapter as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) Qualifications of contractors

(A) In general

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this subchapter or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) Ineligibility of certain contractors

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1395h of this title, a carrier under section 1395u of this title, or a medicare administrative contractor under section 1395kk–1 of this title.

(C) Preference for entities with demonstrated proficiency

In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under subchapter XIX, or under this subchapter.

(7) Construction relating to conduct of investigation of fraud

A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) Annual report

The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this subchapter.

(9) Special rules relating to parts C and D

The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(C) examine claims for reinsurance payments under section 1395w–115(b) of this title to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

(10) Use of certain recovered funds

(A) In general

After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1395*l*(z),[1] 1395m(*l*)(16), and 1395kk–1(a)(4)(G) of this title, carrying out section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this subchapter. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

(B) Limitation

Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

(C) No reduction in payments to recovery audit contractors

Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.

(i) Evaluations and annual report

(1) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(2) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Insurance Trust Fund under section 1395t of this title, to carry out this section; and

(B) the effectiveness of the use of such funds.

(j) Expanding activities of Medicare drug integrity contractors (MEDICs)

(1) Access to information

Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA–PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1395w–104(c)(5)(C) of this title.

(2) Requirement for acknowledgment of referrals

If a PDP sponsor or MA organization refers information to a contractor described in para-

[1] See References in Text note below.

graph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

(A) acknowledge to the sponsor or organization receipt of the referral; and

(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described in such paragraph, shall[2] inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

(3) Making data available to other entities

(A) In general

For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

(B) HIPAA compliant information only

Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(Aug. 14, 1935, ch. 531, title XVIII, § 1893, as added Pub. L. 104–191, title II, § 202(a), Aug. 21, 1996, 110 Stat. 1996; amended Pub. L. 108–173, title VII, § 736(c)(7), title IX, § 935(a), Dec. 8, 2003, 117 Stat. 2356, 2407; Pub. L. 109–171, title VI, § 6034(d)(1), Feb. 8, 2006, 120 Stat. 77; Pub. L. 109–432, div. B, title III, § 302(a), Dec. 20, 2006, 120 Stat. 2991; Pub. L. 111–148, title VI, §§ 6402(j)(1), 6411(b), Mar. 23, 2010, 124 Stat. 762, 775; Pub. L. 114–10, title V, §§ 505(b), 510, Apr. 16, 2015, 129 Stat. 167, 170; Pub. L. 114–115, § 9(b), Dec. 28, 2015, 129 Stat. 3135; Pub. L. 114–198, title VII, § 704(c)(1), July 22, 2016, 130 Stat. 749.)

Editorial Notes

References in Text

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (d)(2)(B), is section 202(b) of Pub. L. 104–191, which amended sections 1395h and 1395u of this title.

Section 1395*l*(z) of this title, referred to in subsec. (h)(10)(A), probably means the subsec. (z) of section 1395*l* of this title which relates to medical review of spinal subluxation services, was added by Pub. L. 114–10, title V, § 514(a), Apr. 16, 2015, 129 Stat. 171, and was redesignated subsec. (aa) by Pub. L. 115–271, title VI, § 6083(b)(1), Oct. 24, 2018, 132 Stat. 3994.

Section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (h)(10)(A), is section 514(b) of Pub. L. 114–10, which is set out as a note under section 1395*l* of this title.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (j)(3)(B), is section 264(c) of Pub. L. 104–191, title II, Aug. 21, 1996, 110 Stat. 2033, which is set out as a note under section 1320d–2 of this title.

Amendments

2016—Subsec. (j). Pub. L. 114–198 added subsec. (j).

2015—Subsec. (g)(1)(A). Pub. L. 114–115, § 9(b)(1), inserted ''or otherwise'' after ''eligible entities'' in introductory provisions.

Subsec. (g)(1)(A)(i). Pub. L. 114–115, § 9(b)(2), inserted ''to review claims data'' after ''algorithms'' and substituted ''provider, service, time, or patient'' for ''service, time, or patient''.

Subsec. (g)(1)(A)(ii). Pub. L. 114–115, § 9(b)(3)(A), inserted ''to investigate and recover amounts with respect to suspect claims'' after ''appropriate actions''.

Subsec. (g)(1)(A)(iv). Pub. L. 114–115, § 9(b)(3)(B)–(5), added cl. (iv).

Subsec. (g)(3). Pub. L. 114–10, § 510, added par. (3).

Subsec. (h)(2). Pub. L. 114–10, § 505(b)(1), inserted ''or paragraph (10)'' after ''paragraph (1)(C)''.

Subsec. (h)(10). Pub. L. 114–10, § 505(b)(2), added par. (10).

2010—Subsec. (a). Pub. L. 111–148, § 6402(j)(1)(C), inserted '', or otherwise,'' after ''entities''.

Subsec. (c)(4), (5). Pub. L. 111–148, § 6402(j)(1)(A), added par. (4) and redesignated former par. (4) as (5)

Subsec. (h)(1). Pub. L. 111–148, § 6411(b)(1), substituted ''this subchapter'' for ''part A or B'' in introductory provisions.

Subsec. (h)(2). Pub. L. 111–148, § 6411(b)(2), substituted ''this subchapter'' for ''parts A and B''.

Subsec. (h)(3). Pub. L. 111–148, § 6411(b)(3), inserted ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010''.

Subsec. (h)(4). Pub. L. 111–148, § 6411(b)(4), substituted ''this subchapter'' for ''part A or B'' in introductory provisions.

Subsec. (h)(9). Pub. L. 111–148, § 6411(b)(5), added par. (9).

Subsec. (i). Pub. L. 111–148, § 6402(j)(1)(B), added subsec. (i).

2006—Subsec. (b)(6). Pub. L. 109–171, § 6034(d)(1)(A), added par. (6).

Subsec. (g). Pub. L. 109–171, § 6034(d)(1)(B), added subsec. (g).

Subsec. (h). Pub. L. 109–432 added subsec. (h).

2003—Subsec. (a). Pub. L. 108–173, § 736(c)(7), substituted ''medicare program'' for ''Medicare program''.

Subsec. (f). Pub. L. 108–173, § 935(a), added subsec. (f).

Statutory Notes and Related Subsidiaries

Effective Date of 2016 Amendment

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

Effective Date of 2003 Amendment

Pub. L. 108–173, title IX, § 935(b), Dec. 8, 2003, 117 Stat. 2411, provided that:

''(1) Use of repayment plans.—Section 1893(f)(1) of the Social Security Act [42 U.S.C. 1395ddd(f)(1)], as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act [Dec. 8, 2003].

''(2) Limitation on recoupment.—Section 1893(f)(2) of the Social Security Act [42 U.S.C. 1395ddd(f)(2)], as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

''(3) Use of extrapolation.—Section 1893(f)(3) of the Social Security Act [42 U.S.C. 1395ddd(f)(3)], as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

[2] So in original. The word ''shall'' probably should not appear.

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act [42 U.S.C. 1395ddd(f)(4)], as added by subsection (a), shall take effect on the date of the enactment of this Act.

''(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act [42 U.S.C. 1395ddd(f)(5)], as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

''(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary [of Health and Human Services] shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) [1893(f)(6)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(6)], as added by subsection (a).

''(7) PAYMENT AUDITS.—Section 1893A(f)(7) [1893(f)(7)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(7)], as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

''(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act [42 U.S.C. 1395ddd(f)(8)], as added by subsection (a).''

IMPROVING THE SHARING OF DATA BETWEEN THE FEDERAL GOVERNMENT AND STATE MEDICAID PROGRAMS

Pub. L. 114–115, § 9, Dec. 28, 2015, 129 Stat. 3135, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a plan to encourage and facilitate the participation of States in the Medicare-Medicaid Data Match Program (commonly referred to as the 'Medi-Medi Program') under section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)).

''(b) PROGRAM REVISIONS TO IMPROVE MEDI-MEDI DATA MATCH PROGRAM PARTICIPATION BY STATES.—[Amended this section.]

''(c) PROVIDING STATES WITH DATA ON IMPROPER PAYMENTS MADE FOR ITEMS OR SERVICES PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary shall develop and implement a plan that allows each State agency responsible for administering a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] access to relevant data on improper or fraudulent payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care items or services provided to dual eligible individuals.

''(2) DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of title XVIII of such Act (42 U.S.C. 1395j et seq.), and is eligible for medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.''

EXTENSION OF TWO-MIDNIGHT RULE

Pub. L. 113–93, title I, § 111, Apr. 1, 2014, 128 Stat. 1044, as amended by Pub. L. 114–10, title V, § 521, Apr. 16, 2015, 129 Stat. 176, provided that:

''(a) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—The Secretary of Health and Human Services may continue medical review activities described in the notice entitled 'Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013', posted on the Internet website of the Centers for Medicare & Medicaid Services, through through [sic] the end of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.

''(b) LIMITATION.—The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) for inpatient claims with dates of admission October 1, 2013, through September 30, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services (as defined in section 1861(u) of such Act (42 U.S.C. 1395x(u))).

''(c) CONSTRUCTION.—Except as provided in subsections (a) and (b), nothing in this section shall be construed as limiting the Secretary's authority to pursue fraud and abuse activities under such section 1893(h) or otherwise.''

ACCESS TO COORDINATION OF BENEFITS CONTRACTOR DATABASE

Pub. L. 109–432, div. B, title III, § 302(b), Dec. 20, 2006, 120 Stat. 2992, provided that: ''The Secretary of Health and Human Services shall provide for access by recovery audit contractors conducting audit and recovery activities under section 1893(h) of the Social Security Act [42 U.S.C. 1395ddd(h)], as added by subsection (a), to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services with respect to the audit and recovery periods described in paragraph (4) of such section 1893(h).''

§ 1395eee. Payments to, and coverage of benefits under, programs of all-inclusive care for elderly (PACE)

(a) Receipt of benefits through enrollment in PACE program; definitions for PACE program related terms

(1) Benefits through enrollment in a PACE program

In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this subchapter solely through such program; and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) "PACE program" defined

For purposes of this section, the term ''PACE program'' means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and

whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) "PACE provider" defined

(A) In general

For purposes of this section, the term ''PACE provider'' means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) "PACE program agreement" defined

For purposes of this section, the term ''PACE program agreement'' means, with respect to a PACE provider, an agreement, consistent with this section, section 1396u–4 of this title (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) "PACE program eligible individual" defined

For purposes of this section, the term ''PACE program eligible individual'' means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) "PACE protocol" defined

For purposes of this section, the term ''PACE protocol'' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) "PACE demonstration waiver program" defined

For purposes of this section, the term ''PACE demonstration waiver program'' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) "State administering agency" defined

For purposes of this section, the term ''State administering agency'' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under subchapter XIX in the State) responsible for administering PACE program agreements under this section and section 1396u–4 of this title in the State.

(9) "Trial period" defined

(A) In general

For purposes of this section, the term ''trial period'' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) "Regulations" defined

For purposes of this section, the term ''regulations'' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1396u–4 of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals enrolled with the provider, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under this subchapter (for individuals enrolled under this section) and all items and services covered under subchapter XIX, but without any limitation or condition as to

amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this subchapter or such subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law that are designed for the protection of patients.

(3) Treatment of medicare services furnished by noncontract physicians and other entities

(A) Application of medicare advantage requirement with respect to medicare services furnished by noncontract physicians and other entities

Section 1395w–22(k)(1) of this title (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under this subchapter) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) Reference to related provision for noncontract providers of services

For the provision relating to limitations on balance billing against PACE providers for services covered under this subchapter furnished by noncontract providers of services, see section 1395cc(a)(1)(O) of this title.

(4) Reference to related provision for services covered under subchapter XIX but not under this subchapter

For provisions relating to limitations on payments to providers participating under the State plan under subchapter XIX that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under this subchapter) when such services are furnished to enrollees of that PACE provider, see section 1396a(a)(66) of this title.

(c) Eligibility determinations

(1) In general

The determination of whether an individual is a PACE program eligible individual—

(A) shall be made under and in accordance with the PACE program agreement; and

(B) who is entitled to medical assistance under subchapter XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential PACE program eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and section 1396u–4 of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term ''noncompliant behavior'' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed nonvoluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+Choice organization under section 1395w–23 of this title (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1395mm of this title). Such payments shall be subject to adjustment in the manner described in section 1395w–23(a)(2) of this title or section 1395mm(a)(1)(E) of this title, as the case may be.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1395w–23 of this title (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1395mm of this title) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this subchapter for a comparable population not enrolled under a PACE program.

(3) Capitation rates determined without regard to the phase-out of the indirect costs of medical education from the annual Medicare Advantage capitation rate

Capitation amounts under this subsection shall be determined without regard to the application of section 1395w–23(k)(4) of this title.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1396u–4 of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of August 5, 1997; or

(II) as of each succeeding anniversary of August 5, 1997, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h); or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) Service area overlap

In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) Data collection; development of outcome measures

(A) Data collection

(i) In general

Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) make available to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this section and section 1396u–4 of this title.

(ii) Requirements during trial period

During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) Development of outcome measures

Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an on-site visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a pro-

gram or provider under this section or section 1396u–4 of this title; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1396u–4 of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1395w–27(g)(2) (or, for periods before January 1, 1999, section 1395mm(i)(6)(B) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in section 1395w–27(g)(1) (or section 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396u–4 of this title, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of section 1395w–27(h) of this title (or for periods before January 1, 1999, section 1395mm(i)(9) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C (or for such periods an eligible organization under section 1395mm of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and section 1396u–4 of this title.

(2) Use of PACE protocol

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1396u–4 of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long-term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) Continuation of modifications or waivers of operational requirements under demonstration status

If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1, 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1395mm of this title) and sections 1396b(m) and 1396u–2 of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1395mm of this title) and to medicaid managed care organizations under prepaid capitation agreements under section 1396b(m) of this title.

(B) Considerations

In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C (or, for periods before January 1, 1999, section 1395mm of this title) and section 1396b(m) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XIX.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1395d of this title, insofar as it limits coverage of institutional services.

(2) Sections 1395e, 1395f, 1395*l*, and 1395ww of this title, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1395f(a)(2)(B), 1395f(a)(2)(C), and 1395n(a)(2)(A) of this title, insofar as they limit coverage of extended care services or home health services.

(4) Section 1395x(i) of this title, insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Paragraphs (1) and (9) of section 1395y(a) of this title, insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) Miscellaneous provisions

Nothing in this section or section 1396u–4 of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under subchapter XIX of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1894, as added Pub. L. 105–33, title IV, § 4801, Aug. 5, 1997, 111 Stat. 528; amended Pub. L. 106–554, § 1(a)(6) [title IX, § 902(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–582; Pub. L. 108–173, title II, § 236(a)(2), Dec. 8, 2003, 117 Stat. 2210; Pub. L. 110–275, title I, § 161(c), July 15, 2008, 122 Stat. 2569; Pub. L. 111–148, title III, § 3201(i)(1), Mar. 23, 2010, 124 Stat. 453; Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(3)(A)(i), is classified generally to Title 26, Internal Revenue Code.

Section 4804(b) of the Balanced Budget Act of 1997, referred to in subsec. (a)(3)(B)(ii), is section 4804(b) of Pub. L. 105–33, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (a)(7)(A), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(7)(A), is section 9220 of Pub. L. 99–272, title IX, Apr. 7, 1986, 100 Stat. 183, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsecs. (a)(7)(B) and (e)(1)(B)(i), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set out below.

AMENDMENTS

2010—Subsecs. (h) to (j). Pub. L. 111–148, § 3201(i)(1), which directed addition of subsec. (h) and the redesignation of former subsecs. (h) and (i) as (i) and (j), respectively, was repealed by Pub. L. 111–152, § 1102(a). Prior to repeal, text of subsec. (h) read as follows:

''With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

''(1) Section 1395w–23(j)(1)(A)(i) of this title, relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

''(2) Section 1395w–23(d)(5) of this title, relating to the establishment of MA local plan service areas.

''(3) Section 1395w–23(n) of this title, relating to the payment of performance bonuses.

''(4) Section 1395w–23(*o*) of this title, relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

''(5) Section 1395w–23(p) of this title, relating to transitional extra benefits.''

See Effective Date of 2010 Amendment note below.

2008—Subsec. (d)(3). Pub. L. 110–275 added par. (3).

2003—Subsec. (b)(3), (4). Pub. L. 108–173 added pars. (3) and (4).

2000—Subsec. (f)(2)(C). Pub. L. 106–554 added subpar. (C).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of section 3201 of Pub. L. 111–148 and the amendments made by such section, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, § 1(a)(6) [title IX, § 902(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–583, provided that: ''The amendments made by this section [amending this section and section 1396u–4 of this title] shall be effective as [if] included in the enactment of BBA [Pub. L. 105–33].''

RURAL PACE PROVIDER GRANT PROGRAM

Pub. L. 109–171, title V, § 5302, Feb. 8, 2006, 120 Stat. 51, as amended by Pub. L. 109–432, div. B, title II, § 205(a), Dec. 20, 2006, 120 Stat. 2989, provided that:

''(a) DEFINITIONS.—In this section:

''(1) CMS.—The term 'CMS' means the Centers for Medicare & Medicaid Services.

''(2) PACE PROGRAM.—The term 'PACE program' has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).

''(3) PACE PROVIDER.—The term 'PACE provider' has the meaning given that term in section 1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).

''(4) RURAL AREA.—The term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

''(5) RURAL PACE PILOT SITE.—The term 'rural PACE pilot site' means a PACE provider that has been approved to provide services in a geographic service area that is, in whole or in part, a rural area, and that has received a site development grant under this section.

''(6) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(b) SITE DEVELOPMENT GRANTS AND TECHNICAL ASSISTANCE PROGRAM.—

''(1) SITE DEVELOPMENT GRANTS.—

''(A) IN GENERAL.—The Secretary shall establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area.

''(B) AMOUNT PER AWARD.—A site development grant awarded under subparagraph (A) to any individual rural PACE pilot site shall not exceed $750,000.

''(C) NUMBER OF AWARDS.—Not more than 15 rural PACE pilot sites shall be awarded a site development grant under subparagraph (A).

''(D) USE OF FUNDS.—Funds made available under a site development grant awarded under subparagraph (A) may be used for the following expenses only to the extent such expenses are incurred in relation to establishing or delivering PACE program services in a rural area:

''(i) Feasibility analysis and planning.

''(ii) Interdisciplinary team development.

''(iii) Development of a provider network, including contract development.

''(iv) Development or adaptation of claims processing systems.

''(v) Preparation of special education and outreach efforts required for the PACE program.

''(vi) Development of expense reporting required for calculation of outlier payments or reconciliation processes.

''(vii) Development of any special quality of care or patient satisfaction data collection efforts.

''(viii) Establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size.

''(ix) Startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS.

''(x) Any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

''(E) APPROPRIATION.—

''(i) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, $7,500,000.

''(ii) AVAILABILITY.—Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2008.

''(2) TECHNICAL ASSISTANCE PROGRAM.—The Secretary shall establish a technical assistance program to provide—

''(A) outreach and education to State agencies and provider organizations interested in establishing PACE programs in rural areas; and

''(B) technical assistance necessary to support rural PACE pilot sites.

''(c) COST OUTLIER PROTECTION FOR RURAL PACE PILOT SITES.—

''(1) ESTABLISHMENT OF FUND FOR REIMBURSEMENT OF OUTLIER COSTS.—Notwithstanding any other provision of law, the Secretary shall establish an outlier fund to reimburse rural PACE pilot sites for recognized outlier costs (as defined in paragraph (3)) incurred for eligible outlier participants (as defined in paragraph (2)) in an amount, subject to paragraph (4), equal to 80 percent of the amount by which the recognized outlier costs exceeds $50,000.

''(2) ELIGIBLE OUTLIER PARTICIPANT.—For purposes of this subsection, the term 'eligible outlier participant' means a PACE program eligible individual (as

defined in sections 1894(a)(5) and 1934(a)(5) of the Social Security Act (42 U.S.C. 1395eee(a)(5); 1396u–4(a)(5))) who resides in a rural area and with respect to whom the rural PACE pilot site incurs more than $50,000 in recognized costs in a 12-month period.

''(3) RECOGNIZED OUTLIER COSTS DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recognized outlier costs' means, with respect to services furnished to an eligible outlier participant by a rural PACE pilot site, the least of the following (as documented by the site to the satisfaction of the Secretary) for the provision of inpatient and related physician and ancillary services for the eligible outlier participant in a given 12-month period:

''(i) If the services are provided under a contract between the pilot site and the provider, the payment rate specified under the contract.

''(ii) The payment rate established under the original Medicare fee-for-service program for such service.

''(iii) The amount actually paid for the services by the pilot site.

''(B) INCLUSION IN ONLY ONE PERIOD.—Recognized outlier costs may not be included in more than one 12-month period.

''(3)[two pars. (3) have been enacted] OUTLIER EXPENSE PAYMENT.—

''(A)[no subpar. (B) has been enacted] PAYMENT FOR OUTLIER COSTS.—Subject to subparagraph (B), in the case of a rural PACE pilot site that has incurred outlier costs for an eligible outlier participant, the rural PACE pilot site shall receive an outlier expense payment equal to 80 percent of such costs that exceed $50,000.

''(4) LIMITATIONS.—

''(A) COSTS INCURRED PER ELIGIBLE OUTLIER PARTICIPANT.—The total amount of outlier expense payments made under this subsection to a rural PACE pilot site with respect to an eligible outlier participant for any 12-month period shall not exceed $100,000 for the 12-month period used to calculate the payment.

''(B) COSTS INCURRED PER PROVIDER.—No rural PACE pilot site may receive more than $500,000 in total outlier expense payments in a 12-month period.

''(C) LIMITATION OF OUTLIER COST REIMBURSEMENT PERIOD.—A rural PACE pilot site shall only receive outlier expense payments under this subsection with respect to costs incurred during the first 3 years of the site's operation.

''(5) REQUIREMENT TO ACCESS RISK RESERVES PRIOR TO PAYMENT.—A rural PACE pilot site shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) and any working capital established through a site development grant awarded under subsection (b)(1), prior to receiving any payment from the outlier fund.

''(6) APPLICATION.—In order to receive an outlier expense payment under this subsection with respect to an eligible outlier participant, a rural PACE pilot site shall submit an application containing—

''(A) documentation of the costs incurred with respect to the participant;

''(B) a certification that the site has complied with the requirements under paragraph (4); and

''(C) such additional information as the Secretary may require.

''(7) APPROPRIATION.—

''(A) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $10,000,000 to carry out this subsection for the period of fiscal years 2006 through 2010.

''(B) AVAILABILITY.—Funds appropriated under subparagraph (A) shall remain available for obligation through fiscal year 2010.

''(d) EVALUATION OF PACE PROVIDERS SERVING RURAL SERVICE AREAS.—Not later than 60 months after the date of enactment of this Act [Feb. 8, 2006], the Secretary shall submit a report to Congress containing an evaluation of the experience of rural PACE pilot sites.

''(e) AMOUNTS IN ADDITION TO PAYMENTS UNDER SOCIAL SECURITY ACT.—Any amounts paid under the authority of this section to a PACE provider shall be in addition to payments made to the provider under section 1894 or 1934 of the Social Security Act (42 U.S.C. 1395eee; 1396u–4).''

FLEXIBILITY IN EXERCISING WAIVER AUTHORITY

Pub. L. 106–554, §1(a)(6) [title IX, §903], Dec. 21, 2000, 114 Stat. 2763, 2763A–583, provided that: ''In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u–4(f)(2)(B)), the Secretary of Health and Human Services—

''(1) shall approve or deny a request for a modification or a waiver of provisions of the PACE protocol not later than 90 days after the date the Secretary receives the request; and

''(2) may exercise authority to modify or waive such provisions in a manner that responds promptly to the needs of PACE programs relating to areas of employment and the use of community-based primary care physicians.''

TRANSITION; REGULATIONS

Pub. L. 105–33, title IV, §4803, Aug. 5, 1997, 111 Stat. 549, as amended by Pub. L. 106–554, §1(a)(6) [title IX, §901], Dec. 21, 2000, 114 Stat. 2763, 2763A–582, provided that:

''(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle [subtitle I (§§4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title, amending sections 1396b, 1396d, 1396r–5, and 1396v of this title, and enacting provisions set out as notes under this section and section 1395b–6 of this title] in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1934 of the Social Security Act [42 U.S.C. 1395eee, 1396u–4] (as added by sections 4801 and 4802 of this subtitle) for periods beginning not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997].

''(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

''(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 [see subsec. (d) below], as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

''(A) in paragraph (1), by inserting before the period at the end the following: ', except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in sections 1894(e)(1)(B) and 1934(e)(1)(B) of the Social Security Act' [42 U.S.C. 1395eee(e)(1)(B), 1396u–4(e)(1)(B)]; and

''(B) in paragraph (2)—

''(i) in subparagraph (A), by striking ', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk'; and

''(ii) in subparagraph (C), by adding at the end the following: 'In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.'

''(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act [Aug. 5, 1997].

''(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such

section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act [Aug. 5, 1997]:

''(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1934 of the Social Security Act [42 U.S.C. 1395eee, 1396u–4]—

''(A) first, to entities that are operating a PACE demonstration waiver program (as defined in sections 1894(a)(7) and 1934(a)(7) of such Act [42 U.S.C. 1395eee(a)(7), 1396u–4(a)(7)]); and

''(B) then to entities that have applied to operate such a program as of May 1, 1997.

''(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 [see subsec. (d) below]—

''(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

''(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

''(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

''(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

''(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21) [97 Stat. 168].

''(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) [100 Stat. 183].

''(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) [100 Stat. 2062].

''(2) DELAY IN APPLICATION TO CURRENT WAIVERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before July 1, 2000, the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 36 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

''(B) STATE OPTION TO SEEK EXTENSION OF CURRENT PERIOD.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act [Aug. 5, 1997]) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 4 years after the initial effective date of regulations described in subsection (a). If a State makes such an election, the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs.''

PACE PROGRAMS; STUDY AND REPORTS

Pub. L. 105–33, title IV, § 4804(a), (b), Aug. 5, 1997, 111 Stat. 551, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act [42 U.S.C. 1395eee(a)(8), 1396u–4(a)(8)]) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

''(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act [42 U.S.C. 1395eee(h), 1396u–4(h)] with the costs, quality, and access to services of other PACE providers.

''(b) REPORT.—

''(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

''(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

''(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

''(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

''(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

''(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.''

§ 1395fff. Prospective payment for home health services

(a) In general

Notwithstanding section 1395x(v) of this title, the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) System of prospective payment for home health services

(1) In general

The Secretary shall establish under this subsection a prospective payment system for pay-

ment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of August 5, 1997, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this subchapter that exceed the aggregate payments that would be made if such a transition did not occur.

(2) Unit of payment

(A) In general

In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

(B) 30-day unit of service

For purposes of implementing the prospective payment system with respect to home health units of service furnished during a year beginning with 2020, the Secretary shall apply a 30-day unit of service as the unit of service applied under this paragraph.

(3) Payment basis

(A) Initial basis

(i) In general

Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted.

(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

(III) Subject to clause (iii), for periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) Reduction

The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits are in effect on September 30, 2000.

(iii) Adjustment for 2014 and subsequent years

(I) In general

Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

(II) Transition

The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2017. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of March 23, 2010.

(iv) Budget neutrality for 2020

With respect to payments for home health units of service furnished that end during the 12-month period beginning January 1, 2020, the Secretary shall calculate a standard prospective payment amount (or amounts) for 30-day units of service (as described in paragraph (2)(B)) for the prospective payment system under this sub-

section. Such standard prospective payment amount (or amounts) shall be calculated in a manner such that the estimated aggregate amount of expenditures under the system during such period with application of paragraph (2)(B) is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system during such period if paragraph (2)(B) had not been enacted. The previous sentence shall be applied before (and not affect the application of) paragraph (3)(B). In calculating such amount (or amounts), the Secretary shall make assumptions about behavior changes that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) and shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.

(B) Annual update

(i) In general

The standard prospective payment amount (or amounts) shall be adjusted for fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004) in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year or year involved.

(ii) Home health applicable increase percentage

For purposes of this subparagraph, the term ''home health applicable increase percentage'' means, with respect to—

(I) each of fiscal years 2002 and 2003, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

(II) for[1] the last calendar quarter of 2003 and the first calendar quarter of 2004, the home health market basket percentage increase;

(III) the last 3 calendar quarters of 2004, and all of 2005[2] the home health market basket percentage increase minus 0.8 percentage points;

(IV) 2006, 0 percent; and

(V) any subsequent year, subject to clauses (v) and (vi), the home health market basket percentage increase.

(iii) Home health market basket percentage increase

For purposes of this subsection, the term ''home health market basket percentage increase'' means, with respect to a fiscal year or year, a percentage (estimated by the Secretary before the beginning of the fiscal year or year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1395ww(b)(3)(B)(iii) of this title is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year. Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent and for 2020 shall be 1.5 percent.

(iv) Adjustment for case mix changes

Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year (or estimates that such adjustments for a future fiscal year or year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year or year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years or years so as to eliminate the effect of such coding or classification changes.

(v) Adjustment if quality data not submitted

(I) Adjustment

For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclauses (II) and (IV) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.

(II) Submission of quality data

Subject to subclause (V), for 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

(III) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subclause (II) and subclause (IV)(aa) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.

[1] So in original. The word ''for'' probably should not appear.

[2] So in original. Probably should be followed by a comma.

(IV) Submission of additional data

(aa) In general

For the year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395*lll* of this title), as applicable with respect to home health agencies and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent year, in addition to the data described in subclause (II), each home health agency shall submit to the Secretary data on such quality measures and any necessary data specified by the Secretary under such subsection (d)(1).

(bb) Standardized patient assessment data

For 2019 and each subsequent year, in addition to such data described in item (aa), each home health agency shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395*lll* of this title.

(cc) Submission

Data shall be submitted under items (aa) and (bb) in the form and manner, and at the time, specified by the Secretary for purposes of this clause.

(V) Non-duplication

To the extent data submitted under subclause (IV) duplicates other data required to be submitted under subclause (II), the submission of such data under subclause (IV) shall be in lieu of the submission of such data under subclause (II). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395*lll* of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(vi) Adjustments

After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

(I) for 2015 and each subsequent year (except 2018 and 2020), by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) for each of 2011, 2012, and 2013, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.

(C) Adjustment for outliers

The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.

(D) Behavior assumptions and adjustments

(i) In general

The Secretary shall annually determine the impact of differences between assumed behavior changes (as described in paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026.

(ii) Permanent adjustments

The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more permanent increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures (as determined under clause (i)).

(iii) Temporary adjustments for retrospective behavior

The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more temporary increases or decreases to the payment amount for a unit of home health services (as determined under paragraph (4)) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures (as determined under clause (i)). Such a temporary increase or decrease shall apply only with respect to the year for which such temporary increase or decrease is made, and the Secretary shall not take into account such a temporary increase or decrease in computing such amount under this subsection for a subsequent year.

(4) Payment computation

(A) In general

The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) Case mix adjustment

The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) Area wage adjustment

The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for

the area in which the services are furnished or such other area as the Secretary may specify.

(B) Establishment of case mix adjustment factors

(i) In general

The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(ii) Treatment of therapy thresholds

For 2020 and subsequent years, the Secretary shall eliminate the use of therapy thresholds (established by the Secretary) in case mix adjustment factors established under clause (i) for calculating payments under the prospective payment system under this subsection.

(C) Establishment of area wage adjustment factors

The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1395ww(d)(3)(E) of this title.

(5) Outliers

(A) In general

Subject to subparagraph (B), the Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(B) Program specific outlier cap

The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.

(6) Proration of prospective payment amounts

If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

(c) Requirements for payment information

With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this subchapter unless—

(1) the claim has the unique identifier for the physician[2] the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title), or the physician assistant (as defined in section 1395x(aa)(5) of this title) who prescribed the services or made the certification described in section 1395f(a)(2) or 1395n(a)(2)(A) of this title;

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1395x(m) of this title, the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments; and

(3) in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.

(d) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of—

(1) the establishment of a transition period under subsection (b)(1);

(2) the definition and application of payment units under subsection (b)(2);

(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

(6) the establishment of any adjustments for outliers under subsection (b)(5).

(e) Construction related to home health services

(1) Telecommunications

Nothing in this section shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established by this section for such units of service from furnishing services via a telecommunication system if such services—

(A) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician[2] a nurse practitioner or clinical nurse specialist, or a physician assistant pursuant to section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title; and

(B) are not considered a home health visit for purposes of eligibility or payment under this subchapter.

(2) Rule of construction regarding requirement for certification

Nothing in this section shall be construed as waiving the requirement for a certification under section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title for the payment for home health services, whether or not furnished via a telecommunications system.

(Aug. 14, 1935, ch. 531, title XVIII, § 1895, as added Pub. L. 105–33, title IV, § 4603(a), Aug. 5, 1997, 111

Stat. 467; amended Pub. L. 105–277, div. J, title V, § 5101(c)(1), (d)(2), Oct. 21, 1998, 112 Stat. 2681–914; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, §§ 302(b), 303(b), 306, 321(k)(19)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359, 1501A–361, 1501A–362, 1501A–368; Pub. L. 106–554, § 1(a)(6) [title V, §§ 501(a), (c)(1), 504], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, 2763A–531; Pub. L. 108–173, title VII, § 701, Dec. 8, 2003, 117 Stat. 2334; Pub. L. 109–171, title V, § 5201(a), (c), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, §§ 3131(a)(1), (b), 3401(e), title X, §§ 10315(a), 10319(d), Mar. 23, 2010, 124 Stat. 427, 428, 483, 944, 949; Pub. L. 113–185, § 2(c)(1), Oct. 6, 2014, 128 Stat. 1962; Pub. L. 114–10, title IV, § 411(c), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title II, § 50208(a)(2), title X, § 51001(a), title XII, § 53110, Feb. 9, 2018, 132 Stat. 189, 289, 304; Pub. L. 116–136, div. A, title III, § 3708(d), Mar. 27, 2020, 134 Stat. 421.)

Editorial Notes

REFERENCES IN TEXT

Section 5201(d) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(v)(I), is section 5201(d) of title V of Pub. L. 109–171, Feb. 8, 2006, 120 Stat. 47, which is not classified to the Code.

AMENDMENTS

2020—Subsec. (c)(1). Pub. L. 116–136, § 3708(d)(1), struck out ''(provided under section 1395u(r) of this title)'' after ''unique identifier'' and inserted ''the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title), or the physician assistant (as defined in section 1395x(aa)(5) of this title)'' after ''physician''.

Subsec. (e)(1)(A). Pub. L. 116–136, § 3708(d)(2)(A), inserted ''a nurse practitioner or clinical nurse specialist, or a physician assistant'' after ''physician''.

Subsec. (e)(2). Pub. L. 116–136, § 3708(d)(2)(B), substituted ''Rule of construction regarding requirement for certification'' for ''Physician certification'' in heading and struck out ''physician'' before ''certification'' in text.

2018—Subsec. (b)(2). Pub. L. 115–123, § 51001(a)(1), inserted subpar. (A) designation and heading before ''In defining'' and added subpar. (B).

Subsec. (b)(3)(A)(iv). Pub. L. 115–123, § 51001(a)(2)(A), added cl. (iv).

Subsec. (b)(3)(B)(iii). Pub. L. 115–123, § 53110(1), inserted ''and for 2020 shall be 1.5 percent'' after ''1 percent''.

Subsec. (b)(3)(B)(vi)(I). Pub. L. 115–123, § 53110(2), inserted ''and 2020'' after ''except 2018''.

Subsec. (b)(3)(D). Pub. L. 115–123, § 51001(a)(2)(B), added subpar. (D).

Subsec. (b)(4)(B). Pub. L. 115–123, § 51001(a)(3), inserted cl. (i) designation and heading before ''The Secretary'' and added cl. (ii).

Subsec. (c)(3). Pub. L. 115–123, § 50208(a)(2), added par. (3).

2015—Subsec. (b)(3)(B)(iii). Pub. L. 114–10, § 411(c)(1), inserted at end ''Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent.''

Subsec. (b)(3)(B)(vi)(I). Pub. L. 114–10, § 411(c)(2), inserted ''(except 2018)'' after ''each subsequent year''.

2014—Subsec. (b)(3)(B)(v)(I). Pub. L. 113–185, § 2(c)(1)(A), substituted ''subclauses (II) and (IV)'' for ''subclause (II)''.

Subsec. (b)(3)(B)(v)(II). Pub. L. 113–185, § 2(c)(1)(B), substituted ''Subject to subclause (V), for 2007'' for ''For 2007''.

Subsec. (b)(3)(B)(v)(III). Pub. L. 113–185, § 2(c)(1)(C), inserted ''and subclause (IV)(aa)'' after ''subclause (II)''.

Subsec. (b)(3)(B)(v)(IV), (V). Pub. L. 113–185, § 2(c)(1)(D), added subcls. (IV) and (V).

2010—Subsec. (b)(3)(A)(i)(III). Pub. L. 111–148, § 3131(a)(1)(A), substituted ''Subject to clause (iii), for periods'' for ''For periods''.

Subsec. (b)(3)(A)(iii). Pub. L. 111–148, § 10315(a), substituted ''2014'' for ''2013'' in heading and in subcl. (I), and ''2017'' for ''2016'' in subcl. (II).

Pub. L. 111–148, § 3131(a)(1)(B), added cl. (iii).

Subsec. (b)(3)(B)(ii)(V). Pub. L. 111–148, § 3401(e)(1), substituted ''clauses (v) and (vi)'' for ''clause (v)''.

Subsec. (b)(3)(B)(vi). Pub. L. 111–148, § 3401(e)(2), added cl. (vi).

Subsec. (b)(3)(B)(vi)(II). Pub. L. 111–148, § 10319(d), substituted '', 2012, and 2013'' for ''and 2012''.

Subsec. (b)(3)(C). Pub. L. 111–148, § 3131(b)(1), substituted ''5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.'' for ''the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).''

Subsec. (b)(5). Pub. L. 111–148, § 3131(b)(2), designated existing provisions as subpar. (A), inserted heading, substituted ''Subject to subparagraph (B), the Secretary'' for ''The Secretary'' and ''2.5 percent'' for ''5 percent'', and added subpar. (B).

2006—Subsec. (b)(3)(B)(ii)(III). Pub. L. 109–171, § 5201(a)(1), substituted ''all of 2005'' for ''each of 2005 and 2006''.

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 109–171, § 5201(a)(2), (4), added subcl. (IV). Former subcl. (IV) redesignated (V).

Pub. L. 109–171, § 5201(a)(3), struck out ''2007 and'' before ''any subsequent year''.

Subsec. (b)(3)(B)(ii)(V). Pub. L. 109–171, § 5201(a)(3), (c)(1), redesignated subcl. (IV) as (V) and inserted ''subject to clause (v),'' after ''subsequent year,''.

Subsec. (b)(3)(B)(v). Pub. L. 109–171, § 5201(c)(2), added cl. (v).

2003—Subsec. (b)(3)(B)(i). Pub. L. 108–173, § 701(a)(1), substituted ''fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)'' for ''each fiscal year (beginning with fiscal year 2002)'' and inserted ''or year'' after ''the fiscal year''.

Subsec. (b)(3)(B)(ii)(I). Pub. L. 108–173, § 701(a)(2)(A), struck out ''or'' at end.

Subsec. (b)(3)(B)(ii)(II). Pub. L. 108–173, § 701(b)(1), struck out ''or'' at end.

Pub. L. 108–173, § 701(a)(2)(D), added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(ii)(III). Pub. L. 108–173, § 701(b)(4), added subcl. (III). Former subcl. (III) redesignated (IV).

Pub. L. 108–173, § 701(a)(2)(B), (C), redesignated subcl. (II) as (III) and substituted ''2004 and any subsequent year'' for ''any subsequent fiscal year''.

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 108–173, § 701(b)(2), (3), redesignated subcl. (III) as (IV) and substituted ''2007'' for ''2004''.

Subsec. (b)(3)(B)(iii). Pub. L. 108–173, § 701(a)(3), inserted ''or year'' after ''fiscal year'' wherever appearing.

Subsec. (b)(3)(B)(iv). Pub. L. 108–173, § 701(a)(4), inserted ''or year'' after ''fiscal year'' wherever appearing and ''or years'' after ''fiscal years''.

Subsec. (b)(5). Pub. L. 108–173, § 701(a)(5), inserted ''or year'' after ''fiscal year''.

2000—Subsec. (b)(3)(A)(i)(II). Pub. L. 106–554, § 1(a)(6) [title V, § 501(a)(3)], added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(A)(i)(III). Pub. L. 106–554, § 1(a)(6) [title V, § 501(a)(1), (2)], redesignated subcl. (II) as (III) and substituted ''described in subclause (II)'' for ''described in subclause (I)''.

Subsec. (b)(3)(B)(iv). Pub. L. 106–554, § 1(a)(6) [title V, § 501(c)(1)], added cl. (iv).

Subsec. (e). Pub. L. 106–554, § 1(a)(6) [title V, § 504], added subsec. (e).

1999—Subsec. (b)(1). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(19)], made technical amendment to reference in original act which appears in text as reference to August 5, 1997.

Subsec. (b)(3)(A)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 302(b)], amended heading and text of cl. (i) gen-

erally. Prior to amendment, text read as follows: ''Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(1)], which directed that the second sentence of cl. (i) be amended in subcl. (I) by the insertion of ''and if section 1395x(v)(1)(L)(ix) of this title had not been enacted'' before semicolon, was executed by making the insertion before the period at end of subcl. (I) to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(2)], inserted ''and if section 1395x(v)(1)(L)(ix) of this title had not been enacted'' after ''if the system had not been in effect''.

Subsec. (b)(3)(B)(ii)(I). Pub. L. 106–113, §1000(a)(6) [title III, §306], substituted ''each of fiscal years 2002 and 2003'' for ''fiscal year 2002 or 2003''.

1998—Subsec. (a). Pub. L. 105–277, §5101(c)(1)(A), substituted ''for portions of cost reporting periods occurring on or after October 1, 2000'' for ''for cost reporting periods beginning on or after October 1, 1999''.

Subsec. (b)(3)(A)(i). Pub. L. 105–277, §5101(c)(1)(B)(i), substituted ''fiscal year 2001'' for ''fiscal year 2000''.

Subsec. (b)(3)(A)(ii). Pub. L. 105–277, §5101(c)(1)(B)(ii), substituted ''September 30, 2000'' for ''September 30, 1999''.

Subsec. (b)(3)(B)(i). Pub. L. 105–277, §5101(d)(2)(A), substituted ''home health applicable increase percentage (as defined in clause (ii))'' for ''home health market basket percentage increase''.

Pub. L. 105–277, §5101(c)(1)(B)(iii), substituted ''fiscal year 2002'' for ''fiscal year 2001''.

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 105–277, §5101(d)(2)(B), (C), added cl. (ii) and redesignated former cl. (ii) as (iii).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §501(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to episodes concluding on or after October 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §303(b)] of Pub. L.106–113 applicable to services furnished by home health agencies for cost reporting periods beginning on or after Oct. 1, 1999, see section 1000(a)(6) [title III, §303(c)] of Pub. L. 106–113, set out as a note under section 1395x of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(19)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE

Pub. L. 105–33, title IV, §4603(d), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, §5101(c)(2), Oct. 21, 1998, 112 Stat. 2681–914, provided that: ''Except as otherwise provided, the amendments made by this section [enacting this section and amending sections 1395f, 1395g, 1395k, 1395*l*, 1395u, and 1395y of this title] shall apply to portions of cost reporting periods occurring on or after October 1, 2000.''

STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS

Pub. L. 111–148, title III, §3131(d), title X, §10315(b), Mar. 23, 2010, 124 Stat. 429, 944, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

''(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

''(i) payment adjustments for services that may involve additional or fewer resources;

''(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

''(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

''(iv) other issues determined appropriate by the Secretary.

''(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

''(C) Whether additional research might be needed.

''(D) Other items determined appropriate by the Secretary.

''(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

''(A) population density and relative patient access to care;

''(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

''(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

''(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.]; and

''(E) other factors determined appropriate by the Secretary.

''(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appro-

priate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

''(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

''(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

''(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

''(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

''(i) shall not apply to payments for home health services under title XVIII [42 U.S.C. 1395 et seq.] after such period; and

''(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

''(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

''(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

''(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

''(i) provide for an evaluation of the project; and

''(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

''(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.''

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 108–173, title IV, § 421, Dec. 8, 2003, 117 Stat. 2283, as amended by Pub. L. 109–171, title V, § 5201(b), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, § 3131(c), Mar. 23, 2010, 124 Stat. 428; Pub. L. 114–10, title II, § 210, Apr. 16, 2015, 129 Stat. 151; Pub. L. 115–123, div. E, title II, § 50208(a)(1), Feb. 9, 2018, 132 Stat. 188, provided that:

''(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits ending on or after April 1, 2010, and before January 1, 2019, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary [of Health and Human Services] shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent (or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2019, 3 percent).

''(b) SUBSEQUENT TEMPORARY INCREASE.—

''(1) IN GENERAL.—The Secretary shall increase the payment amount otherwise made under such section 1895 for home health services furnished in a county (or equivalent area) in a rural area (as defined in such section 1886(d)(2)(D)) that, as determined by the Secretary—

''(A) is in the highest quartile of all counties (or equivalent areas) based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled for benefits under part B of such title [42 U.S.C. 1395j et seq.] (but not enrolled in a plan under part C of such title [42 U.S.C. 1395w–21 et seq.])—

''(i) in the case of episodes and visits ending during 2019, by 1.5 percent; and

''(ii) in the case of episodes and visits ending during 2020, by 0.5 percent;

''(B) has a population density of 6 individuals or fewer per square mile of land area and is not described in subparagraph (A)—

''(i) in the case of episodes and visits ending during 2019, by 4 percent;

''(ii) in the case of episodes and visits ending during 2020, by 3 percent;

''(iii) in the case of episodes and visits ending during 2021, by 2 percent; and

''(iv) in the case of episodes and visits ending during 2022, by 1 percent; and

''(C) is not described in either subparagraph (A) or (B)—

''(i) in the case of episodes and visits ending during 2019, by 3 percent;

''(ii) in the case of episodes and visits ending during 2020, by 2 percent; and

''(iii) in the case of episodes and visits ending during 2021, by 1 percent.

''(2) RULES FOR DETERMINATIONS.—

''(A) NO SWITCHING.—For purposes of this subsection, the determination by the Secretary as to which subparagraph of paragraph (1) applies to a county (or equivalent area) shall be made a single time and shall apply for the duration of the period to which this subsection applies.

''(B) UTILIZATION.—In determining which counties (or equivalent areas) are in the highest quartile under paragraph (1)(A), the following rules shall apply:

''(i) The Secretary shall use data from 2015.

''(ii) The Secretary shall exclude data from the territories (and the territories shall not be described in such paragraph).

''(iii) The Secretary may exclude data from counties (or equivalent areas) in rural areas with a low volume of home health episodes (and if data is so excluded with respect to a county (or equivalent area), such county (or equivalent area) shall not be described in such paragraph).

''(C) POPULATION DENSITY.—In determining population density under paragraph (1)(B), the Secretary shall use data from the 2010 decennial Census.

''(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869 [probably means section 1869 of the Social Security Act, 42 U.S.C. 1395ff], section 1878 [probably means section 1878 of the Social Security Act, 42 U.S.C.1395*oo*], or otherwise of determinations under paragraph (1).

''(c) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a) or (b).

''(d) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) or (b) for a period under such subsection—

''(1) shall not apply to episodes and visits ending after such period; and

''(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.''

DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES

Pub. L. 108–173, title VII, §703, Dec. 8, 2003, 117 Stat. 2336, provided that:

''(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary [of Health and Human Services] shall establish a demonstration project (in this section referred to as the 'demonstration project') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

''(b) PAYMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

''(2) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY-CARE SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

''(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day-care services.

''(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

''(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

''(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

''(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

''(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

''(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

''(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

''(i) DEFINITIONS.—In this section:

''(1) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given such term in section 1861(*o*) of the Social Security Act (42 U.S.C. 1395x(*o*)).

''(2) MEDICAL ADULT DAY-CARE FACILITY.—The term 'medical adult day-care facility' means a facility that—

''(A) has been licensed or certified by a State to furnish medical adult day-care services in the State for a continuous 2-year period;

''(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

''(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

''(D) provides medical adult day-care services.

''(3) MEDICAL ADULT DAY-CARE SERVICES.—The term 'medical adult day-care services' means—

''(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) [probably means section 1861(m) of the Social Security Act, 42 U.S.C. 1395x(m)] furnished in a medical adult day-care facility;

''(B) a program of supervised activities furnished in a group setting in the facility that—

''(i) meet such criteria as the Secretary determines appropriate; and

''(ii) is designed to promote physical and mental health of the individuals; and

''(C) such other services as the Secretary may specify.

''(4) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A of this title [probably means part A of title XVIII of the Social Security Act, 42 U.S.C. 1395c et seq.], enrolled under part B of this title [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], or both.''

TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS

Pub. L. 108–173, title VII, §704, Dec. 8, 2003, 117 Stat. 2338, provided that:

''(a) IN GENERAL.—During the period described in subsection (b), the Secretary [of Health and Human Services] may not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) [set out as a note under this section] or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] (such information in this section referred to as 'non-medicare/medicaid OASIS information').

''(b) PERIOD OF SUSPENSION.—The period described in this subsection—

''(1) begins on the date of the enactment of this Act [Dec. 8, 2003]; and

''(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information fol-

lowing the submission of the report required under subsection (c).

''(c) REPORT.—

''(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

''(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

''(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

''(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003].

''(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.''

MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES

Pub. L. 108–173, title VII, §705, Dec. 8, 2003, 117 Stat. 2339, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a report on the study under subsection (a).''

SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS

Pub. L. 106–554, §1(a)(6) [title V, §502(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

''(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending section 1395x of this title], for purposes of making payments under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) for home health services furnished during fiscal year 2001, the Secretary of Health and Human Services shall—

''(A) with respect to episodes and visits ending on or after October 1, 2000, and before April 1, 2001, use the final standardized and budget neutral prospective payment amounts for 60-day episodes and standardized average per visit amounts for fiscal year 2001 as published by the Secretary in the Federal Register on July 3, 2000 (65 Fed. Reg. 41128–41214); and

''(B) with respect to episodes and visits ending on or after April 1, 2001, and before October 1, 2001, use such amounts increased by 2.2 percent.

''(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895 of the Social Security Act.''

TEMPORARY TWO-MONTH PERIODIC INTERIM PAYMENT

Pub. L. 106–554, §1(a)(6) [title V, §503], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

''(a) IN GENERAL.—Notwithstanding the amendments made by section 4603(b) of BBA [Pub. L. 105–33, amending section 1395g of this title] (42 U.S.C. 1395fff note), in the case of a home health agency that was receiving periodic interim payments under section 1815(e)(2) of the Social Security Act (42 U.S.C. 1395g(e)(2)) as of September 30, 2000, and that is not described in subsection (b), the Secretary of Health and Human Services shall, as soon as practicable, make a single periodic interim payment to such agency in an amount equal to four times the last full fortnightly periodic interim payment made to such agency under the payment system in effect prior to the implementation of the prospective payment system under section 1895(b) of such Act (42 U.S.C. 1395fff(b)). Such amount of such periodic interim payment shall be included in the tentative settlement of the last cost report for the home health agency under the payment system in effect prior to the implementation of such prospective payment system, regardless of the ending date of such cost report.

''(b) EXCEPTIONS.—The Secretary shall not make an additional periodic interim payment under subsection (a) in the case of a home health agency (determined as of the day that such payment would otherwise be made) that—

''(1) notifies the Secretary that such agency does not want to receive such payment;

''(2) is not receiving payments pursuant to section 405.371 of title 42, Code of Federal Regulations;

''(3) is excluded from the medicare program under title XI of the Social Security Act [42 U.S.C. 1301 et seq.];

''(4) no longer has a provider agreement under section 1866 of such Act (42 U.S.C. 1395cc);

''(5) is no longer in business; or

''(6) is subject to a court order providing for the withholding of medicare payments under title XVIII of such Act [42 U.S.C. 1395 et seq.].''

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 106–554, §1(a)(6) [title V, §508], Dec. 21, 2000, 114 Stat. 2763, 2763A–533, provided that:

''(a) 24-MONTH INCREASE BEGINNING APRIL 1, 2001.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after April 1, 2001, and before April 1, 2003, the Secretary of Health and Human Services shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

''(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).''

CLARIFICATION OF APPLICATION OF TEMPORARY PAYMENT INCREASES FOR 2001

Pub. L. 106–554, §1(a)(6) [title V, §547(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that:

''(1) TRANSITIONAL ALLOWANCE FOR FULL MARKETBASKET [SIC] INCREASE.—The payment increase provided under section 502(b)(1)(B) [set out as a note above] shall not apply to episodes and visits ending after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for subsequent episodes and visits.

''(2) TEMPORARY INCREASE FOR RURAL HOME HEALTH SERVICES.—The payment increase provided under section 508(a) [set out as a note above] for the period beginning on April 1, 2001, and ending on September 30, 2002, shall not apply to episodes and visits ending after such period, and shall not be taken into account in cal-

culating the payment amounts applicable for episodes and visits occurring after such period.''

ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §301], Nov. 29, 1999, 113 Stat. 1536, 1501A–358, provided that:

''(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS

''(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health and Human Services shall pay the agency, in addition to any amount of payment made under section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33] (42 U.S.C. 1395fff note).

''(2) PAYMENT SCHEDULE

''(A) MIDYEAR PAYMENT.—Not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

''(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

''(3) PAYMENT FROM TRUST FUNDS.—Payments under this subsection shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given that term under section 1861(*o*) of the Social Security Act (42 U.S.C. 1395x(*o*)).

''(B) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given that term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

''(C) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

''(b) GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.—

''(1) REPORT TO CONGRESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

''(B) MATTERS STUDIED.—For purposes of subparagraph (A), the matters described in this subparagraph include the following:

''(i) An assessment of the costs incurred by medicare home health agencies in complying with such data collection requirement.

''(ii) An analysis of the effect of such data collection requirement on the privacy interests of patients from whom data is collected.

''(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

''(2) DEFINITIONS.—In this subsection:

''(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term 'comprehensive assessment of patients' means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient's current status and that incorporates the Outcome and Assessment Information Set (OASIS).

''(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term 'Outcome and Assessment Information Set' means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.''

REPORT TO CONGRESS ON NEED FOR REDUCTIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §302(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–360, as amended by Pub. L. 106–554, §1(a)(6) [title V, §501(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: ''Not later than April 1, 2002, the Comptroller General of the United States shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section [42 U.S.C. 1395fff(b)(3)(A)(ii)], or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services established under such section.''

STUDY AND REPORT TO CONGRESS REGARDING EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §307], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as 'MedPAC') shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for such services established by the Secretary of Health and Human Services in accordance with section 1895 of the Social Security Act (42 U.S.C. 1395fff).

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.''

CASE MIX SYSTEM DEVELOPMENT

Pub. L. 105–33, title IV, §4602(d), Aug. 5, 1997, 111 Stat. 467, provided that: ''The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.''

CASE MIX SYSTEM; SUBMISSION OF DATA

Pub. L. 105–33, title IV, §4602(e), Aug. 5, 1997, 111 Stat. 467, provided that: ''Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that

the Secretary considers necessary for the development of a reliable case mix system.''

PROSPECTIVE PAYMENT SYSTEM CONTINGENCY

Pub. L. 105–33, title IV, § 4603(e), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, § 5101(c)(3), Oct. 21, 1998, 112 Stat. 2681–914, provided that if the Secretary of Health and Human Services did not establish and implement the prospective payment system for home health services described in subsec. (b) of this section for portions of cost reporting periods described in section 4603(d) of Pub. L. 105–33 (set out as a note above), for such portions the Secretary was to provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits would otherwise have been in effect on Sept. 30, 2000, prior to repeal by Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 302(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359.

REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT

Pub. L. 105–33, title IV, § 4616, Aug. 5, 1997, 111 Stat. 475, provided that:

''(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for the provision of home health services during each of fiscal years 1998 through 2002.

''(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare program or such other methods as will reduce the growth in outlays for home health services under the medicare program.''

§ 1395ggg. Omitted

Editorial Notes

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XVIII, § 1896, as added Pub. L. 105–33, title IV, § 4015(a), Aug. 5, 1997, 111 Stat. 337; amended Pub. L. 106–398, § 1 [[div. A], title VII, § 712(a)(2), (b)–(e)], Oct. 30, 2000, 114 Stat. 1654, 1654A–177, 1654A–178; Pub. L. 107–314, div. A, title VII, § 713, Dec. 2, 2002, 116 Stat. 2589; Pub. L. 108–173, title VII, § 736(c)(8), Dec. 8, 2003, 117 Stat. 2356, authorized the Secretary of Health and Human Services and the Secretary of Defense, acting jointly, to establish a demonstration project for providing medicare health care services to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider, to be conducted during the 4-year period beginning on January 1, 1998.

§ 1395hhh. Health care infrastructure improvement program

(a) Establishment

The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

(b) Application

No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

(c) Selection criteria

(1) In general

The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(2) Qualifying hospital defined

For purposes of this section, the term ''qualifying hospital'' means a hospital or an entity described in paragraph (3) that—

(A) is engaged in research in the causes, prevention, and treatment of cancer; and

(B) is designated as a cancer center for the National Cancer Institute or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003.

(3) Entity described

An entity described in this paragraph is an entity that—

(A) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(B) has at least 1 existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located; and

(C) retains clinical outpatient treatment for cancer on site as well as lab research and education and outreach for cancer in the same facility.

(d) Projects

A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

(e) State and local permits

The provision of a loan under this section with respect to a project shall not—

(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

(f) Forgiveness of indebtedness

The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the

loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

(C)(i) unique research resources (such as population databases); or

(ii) an affiliation with an entity that has unique research resources.

(g) Funding

(1) In general

There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

(2) Administrative costs

From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

(3) Availability

Amounts appropriated under this section shall be available for obligation on July 1, 2004.

(h) Report to Congress

Not later than 4 years after December 8, 2003, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.

(i) Limitation on review

There shall be no administrative or judicial review of any determination made by the Secretary under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1897, as added Pub. L. 108–173, title X, §1016, Dec. 8, 2003, 117 Stat. 2447; amended Pub. L. 109–13, div. A, title VI, §6045(a), (b), May 11, 2005, 119 Stat. 294.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(A), is classified generally to Title 26, Internal Revenue Code.

The Higher Education Act of 1965, referred to in subsec. (f), is Pub. L. 89–329, Nov. 8, 1965, 79 Stat. 1219. Part D of title IV of the Act is classified generally to part D (§1087a et seq.) of subchapter IV of chapter 28 of Title 20, Education. For complete classification of this Act to the Code, see section 1 of Pub. L. 89–329, set out as a Short Title note under section 1001 of Title 20 and Tables.

AMENDMENTS

2005—Subsec. (c)(2). Pub. L. 109–13, §6045(a)(1)(A), inserted ''or an entity described in paragraph (3)'' after ''means a hospital'' in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 109–13, §6045(a)(1)(B), inserted ''legislature'' after ''designated by the State'' and ''and such designation by the State legislature occurred prior to December 8, 2003'' before period at end.

Subsec. (c)(3). Pub. L. 109–13, §6045(a)(2), added par. (3).

Subsec. (i). Pub. L. 109–13, §6045(b), added subsec. (i).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–13, div. A, title VI, §6045(c), May 11, 2005, 119 Stat. 295, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2447).''

§ 1395iii. Medicare Improvement Fund

(a) Establishment

The Secretary shall establish under this subchapter a Medicare Improvement Fund (in this section referred to as the ''Fund'') which shall be available to the Secretary to make improvements under the original Medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part[1] or enrolled under part B including adjustments to payments for items and services furnished by providers of services and suppliers under such original Medicare fee-for-service program.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund for services furnished during and after fiscal year 2021, $101,000,000.

(2) Payment from Trust Funds

The amount specified under paragraph (1) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.

(3) Funding limitation

Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(4) No effect on payments in subsequent years

In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this subchapter for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.

(Aug. 14, 1935, ch. 531, title XVIII, §1898, as added Pub. L. 110–252, title VII, §7002(a), June 30, 2008,

[1] So in original.

122 Stat. 2394; amended Pub. L. 110–275, title I, § 188(a)(2)(B), July 15, 2008, 122 Stat. 2589; Pub. L. 110–379, § 6, Oct. 8, 2008, 122 Stat. 4079; Pub. L. 111–5, div. B, title IV, § 4103(b), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111–118, div. B, § 1011(b), Dec. 19, 2009, 123 Stat. 3474; Pub. L. 111–148, title III, § 3112, Mar. 23, 2010, 124 Stat. 421; Pub. L. 111–309, title II, § 207, Dec. 15, 2010, 124 Stat. 3291; Pub. L. 112–240, title VI, § 640, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 113–82, § 3, Feb. 15, 2014, 128 Stat. 1009; Pub. L. 113–93, title II, § 219, Apr. 1, 2014, 128 Stat. 1070; Pub. L. 113–185, § 3(e), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title V, § 518, Apr. 16, 2015, 129 Stat. 175; Pub. L. 114–60, § 2(c), Oct. 7, 2015, 129 Stat. 544; Pub. L. 114–113, div. O, title V, § 501, Dec. 18, 2015, 129 Stat. 3018; Pub. L. 114–115, § 5, Dec. 28, 2015, 129 Stat. 3133; Pub. L. 114–198, title VII, § 704(h), July 22, 2016, 130 Stat. 752; Pub. L. 114–255, div. A, title V, § 5001, Dec. 13, 2016, 130 Stat. 1188; Pub. L. 115–63, title III, § 303, Sept. 29, 2017, 131 Stat. 1172; Pub. L. 115–123, div. E, title XII, § 53115, Feb. 9, 2018, 132 Stat. 306; Pub. L. 116–260, div. CC, title IV, § 408, Dec. 27, 2020, 134 Stat. 3008; Pub. L. 117–43, div. D, title I, § 3106, Sept. 30, 2021, 135 Stat. 380; Pub. L. 117–70, div. C, title I, § 2104(b), Dec. 3, 2021, 135 Stat. 1504; Pub. L. 117–71, § 6, Dec. 10, 2021, 135 Stat. 1508.)

Editorial Notes

AMENDMENTS

2021—Subsec. (b)(1). Pub. L. 117–71 substituted ''fiscal year 2021, $101,000,000.'' for ''fiscal year 2021, $69,000,000.''

Pub. L. 117–70 substituted ''$56,000,000'' for ''$69,000,000''.

Pub. L. 117–43 substituted ''$69,000,000'' for ''$165,000,000''.

2020—Subsec. (b)(1). Pub. L. 116–260 substituted ''$165,000,000'' for ''$0''.

2018—Subsec. (b)(1). Pub. L. 115–123 substituted ''$0'' for ''$220,000,000''.

2017—Subsec. (b)(1). Pub. L. 115–63 substituted ''during and after fiscal year 2021, $220,000,000'' for ''during and after fiscal year 2021, $270,000,000''.

2016—Subsec. (b)(1). Pub. L. 114–255 substituted ''$270,000,000'' for ''$140,000,000''.

Pub. L. 114–198 substituted ''during and after fiscal year 2021, $140,000,000'' for ''during and after fiscal year 2020, $0''.

2015—Subsec. (b)(1). Pub. L. 114–115 substituted ''$0'' for ''$5,000,000''.

Pub. L. 114–113 substituted ''$5,000,000'' for ''$205,000,000''.

Pub. L. 114–60 substituted ''$205,000,000'' for ''$0''.

Pub. L. 114–10 substituted ''$0'' for ''$195,000,000''.

2014—Pub. L. 113–185, § 3(e)(1), substituted ''Medicare Improvement Fund'' for ''Transitional Fund for Sustainable Growth Rate (SGR) Reform'' in section catchline.

Pub. L. 113–82, § 3(1), substituted ''Transitional Fund for Sustainable Growth Rate (SGR) Reform'' for ''Medicare Improvement Fund'' in section catchline.

Subsec. (a). Pub. L. 113–185, § 3(e)(2), amended subsec. (a) generally. Prior to amendment, text read as follows: ''The Secretary shall establish under this subchapter a Transitional Fund for Sustainable Growth Rate (SGR) Reform (in this section referred to as the 'Fund') which shall be available to the Secretary to provide funds to pay for physicians' services under part B to supplement the conversion factor under section 1395w–4(d) of this title for 2017 if the conversion factor for 2017 is less than conversion factor for 2013.''

Pub. L. 113–82, § 3(2), amended subsec. (a) generally. Prior to amendment, text read as follows: ''The Secretary shall establish under this subchapter a Medicare Improvement Fund (in this section referred to as the 'Fund') which shall be available to the Secretary to make improvements under the original medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program.''

Subsec. (b)(1). Pub. L. 113–185, § 3(e)(3), substituted ''during and after fiscal year 2020, $195,000,000.'' for ''during or after 2017, $0.''

Pub. L. 113–93 substituted ''$0'' for ''$2,300,000,000''.

Pub. L. 113–82, § 3(3), substituted ''during or after 2017, $2,300,000,000.'' for ''during—

''(A) fiscal year 2014, $0; and

''(B) fiscal year 2015, $0.''

Subsec. (b)(2). Pub. L. 113–185, § 3(e)(4), substituted ''from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.'' for ''from the Federal Supplementary Medical Insurance Trust Fund.''

Pub. L. 113–82, § 3(4), substituted ''from the Federal Supplementary Medical Insurance Trust Fund.'' for ''from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.''

2013—Subsec. (b)(1). Pub. L. 112–240 added subpars. (A) and (B) and struck out former subpars. (A) to (C) which read as follows:

''(A) fiscal year 2014, $0;

''(B) fiscal year 2015, $275,000,000; and

''(C) fiscal year 2020 and each subsequent fiscal year, the Secretary's estimate, as of July 1 of the fiscal year, of the aggregate reduction in expenditures under this subchapter during the preceding fiscal year directly resulting from the reduction in payment amounts under sections 1395w–4(a)(7), 1395w–23(*l*)(4), 1395w–23(m)(4), and 1395ww(b)(3)(B)(ix) of this title.''

2010—Subsec. (b)(1)(A). Pub. L. 111–148, which directed substitution of ''$0'' for ''$22,290,000,000'', was executed by making the substitution for ''$20,740,000,000'' to reflect the probable intent of Congress and the intervening amendment by Pub. L. 111–118, § 1011(b)(1)(A). See 2009 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 111–309 substituted ''$275,000,000'' for ''$550,000,000''.

2009—Subsec. (a). Pub. L. 111–5, § 4103(b)(1), inserted ''medicare'' before ''fee-for-service program under'' and ''including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program'' before period at end.

Subsec. (b)(1). Pub. L. 111–5, § 4103(b)(2)(A), substituted ''during—'' for ''during fiscal year 2014, $2,290,000,000 and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000.'' and added subpars. (A) and (B).

Subsec. (b)(1)(A). Pub. L. 111–118, § 1011(b)(1)(A), substituted ''$20,740,000,000'' for ''$22,290,000,000''.

Subsec. (b)(1)(B), (C). Pub. L. 111–118, § 1011(b)(1)(B)–(3), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (b)(4). Pub. L. 111–5, § 4103(b)(2)(B), added par. (4).

2008—Subsec. (b)(1). Pub. L. 110–379 substituted ''$2,290,000,000'' for ''$2,220,000,000''.

Pub. L. 110–275 inserted ''and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000'' before period at end.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

§ 1395jjj. Shared savings program

(a) Establishment

(1) [1] In general

Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ''program'') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ''ACO''); and

(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

(b) Eligible ACOs

(1) In general

Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

(A) ACO professionals in group practice arrangements.

(B) Networks of individual practices of ACO professionals.

(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

(D) Hospitals employing ACO professionals.

(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

(2) Requirements

An ACO shall meet the following requirements:

(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ''agreement period'').

(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

(I) An ACO that seeks to operate an ACO Beneficiary Incentive Program pursuant to subsection (m) shall apply to the Secretary at such time, in such manner, and with such information as the Secretary may require.

(3) Quality and other reporting requirements

(A) In general

The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

(i) clinical processes and outcomes;

(ii) patient and, where practicable, caregiver experience of care; and

(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

(B) Reporting requirements

An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

(C) Quality performance standards

The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall

[1] So in original. No par. (2) has been enacted.

seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(D) Other reporting requirements

The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1395w–4 of this title, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1395w–4 of this title, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

(4) No duplication in participation in shared savings programs

A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

(A) A model tested or expanded under section 1315a of this title that involves shared savings under this subchapter, or any other program or demonstration project that involves such shared savings.

(B) The independence at home medical practice pilot program under section 1395cc–5 of this title.

(c) Assignment of Medicare fee-for-service beneficiaries to ACOs

(1) In general

Subject to paragraph (2), the Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of—

(A) in the case of performance years beginning on or after April 1, 2012, primary care services provided under this subchapter by an ACO professional described in subsection (h)(1)(A); and

(B) in the case of performance years beginning on or after January 1, 2019, services provided under this subchapter by a Federally qualified health center or rural health clinic (as those terms are defined in section 1395x(aa) of this title), as may be determined by the Secretary.

(2) Providing flexibility

(A) Choice of prospective assignment

For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

(B) Assignment based on voluntary identification by medicare fee-for-service beneficiaries

(i) In general

For performance year 2018 and each subsequent performance year, if a system is available for electronic designation, the Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

(ii) Notification process

The Secretary shall establish a process under which a Medicare fee-for-service beneficiary is—

(I) notified of their ability to make an identification described in clause (i); and

(II) informed of the process by which they may make and change such identification.

(iii) Superseding claims-based assignment

A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede any claims-based assignment otherwise determined by the Secretary.

(d) Payments and treatment of savings

(1) Payments

(A) In general

Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

(ii) the ACO meets the requirement under subparagraph (B)(i).

(B) Savings requirement and benchmark

(i) Determining savings

In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this subchapter, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

(ii) Establish and update benchmark

The Secretary shall estimate a benchmark for each agreement period for each

ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

(2) Payments for shared savings

Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this subchapter. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

(3) Monitoring avoidance of at-risk patients

If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

(4) Termination

The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

(e) Administration

Chapter 35 of title 44 shall not apply to the program, including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(f) Waiver authority

The Secretary may waive such requirements of sections 1320a–7a and 1320a–7b of this title and this subchapter as may be necessary to carry out the provisions of this section.

(g) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of—

(1) the specification of criteria under subsection (a)(1)(B);

(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

(6) the termination of an ACO under subsection (d)(4) or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(h) Definitions

In this section:

(1) ACO professional

The term ''ACO professional'' means—

(A) a physician (as defined in section 1395x(r)(1) of this title); and

(B) a practitioner described in section 1395u(b)(18)(C)(i) of this title.

(2) Hospital

The term ''hospital'' means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title).

(3) Medicare fee-for-service beneficiary

The term ''Medicare fee-for-service beneficiary'' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1395mm of this title, or a PACE program under section 1395eee of this title.

(i) Option to use other payment models

(1) In general

If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

(2) Partial capitation model

(A) In general

Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) No additional program expenditures

Payments to an ACO for items and services under this subchapter for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

(3) Other payment models

(A) In general

Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this subchapter.

(B) No additional program expenditures

Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(j) Involvement in private payer and other third party arrangements

The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

(k) Treatment of physician group practice demonstration

During the period beginning on March 23, 2010, and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1395cc–1 of this title, subject to rebasing and other modifications deemed appropriate by the Secretary.

(*l*) Providing ACOs the ability to expand the use of telehealth services

(1) In general

In the case of telehealth services for which payment would otherwise be made under this subchapter furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

(A) Inclusion of home as originating site

Subject to paragraph (3), the home of a beneficiary shall be treated as an originating site described in section 1395m(m)(4)(C)(ii) of this title.

(B) No application of geographic limitation

The geographic limitation under section 1395m(m)(4)(C)(i) of this title shall not apply with respect to an originating site described in section 1395m(m)(4)(C)(ii) of this title (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

(2) Definitions

In this subsection:

(A) Applicable ACO

The term ''applicable ACO'' means an ACO participating in a model tested or expanded under section 1315a of this title or under this section—

(i) that operates under a two-sided model—

(I) described in section 425.600(a) of title 42, Code of Federal Regulations; or

(II) tested or expanded under section 1315a of this title; and

(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using a prospective assignment method, as determined appropriate by the Secretary.

(B) Home

The term ''home'' means, with respect to a Medicare fee-for-service beneficiary, the place of residence used as the home of the beneficiary.

(3) Telehealth services received in the home

In the case of telehealth services described in paragraph (1) where the home of a Medicare fee-for-service beneficiary is the originating site, the following shall apply:

(A) No facility fee

There shall be no facility fee paid to the originating site under section 1395m(m)(2)(B) of this title.

(B) Exclusion of certain services

No payment may be made for such services that are inappropriate to furnish in the home setting such as services that are typically furnished in inpatient settings such as a hospital.

(m) Authority to provide incentive payments to beneficiaries with respect to qualifying primary care services

(1) Program

(A) In general

In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary's discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

(B) Implementation

The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date shall be no earlier than January 1, 2019, and no later than January 1, 2020.

(2) Conduct of program

(A) Duration

Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be conducted for such period (of not less than 1 year) as the Secretary may approve.

(B) Scope

An ACO Beneficiary Incentive Program established under this subsection shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who

are furnished qualifying services by the ACO:

(i) With respect to the Track 2 and Track 3 payment models described in section 425.600(a) of title 42, Code of Federal Regulations (or in any successor regulation), Medicare fee-for-service beneficiaries who are preliminarily prospectively or prospectively assigned (or otherwise assigned, as determined by the Secretary) to the ACO.

(ii) With respect to any future payment models involving two-sided risk, Medicare fee-for-service beneficiaries who are assigned to the ACO, as determined by the Secretary.

(C) Qualifying service

For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20 of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

(i) an ACO professional described in subsection (h)(1)(A) who has a primary care specialty designation included in the definition of primary care physician under section 425.20 of title 42, Code of Federal Regulations (or any successor regulation);

(ii) an ACO professional described in subsection (h)(1)(B); or

(iii) a Federally qualified health center or rural health clinic (as such terms are defined in section 1395x(aa) of this title).

(D) Incentive payments

An incentive payment made by an ACO pursuant to an ACO Beneficiary Incentive Program established under this subsection shall be—

(i) in an amount up to $20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1395ss(g)(1) of this title), in a State Medicaid plan under subchapter XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

(iii) made for each qualifying service furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B) during a period specified by the Secretary; and

(iv) made no later than 30 days after a qualifying service is furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B).

(E) No separate payments from the Secretary

The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

(F) No application to shared savings calculation

Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

(G) Reporting requirements

An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Secretary may require, including the amount and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

(H) Termination

The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any time for reasons determined appropriate by the Secretary.

(3) Exclusion of incentive payments

Any payment made under an ACO Beneficiary Incentive Program established under this subsection shall not be considered income or resources or otherwise taken into account for purposes of—

(A) determining eligibility for benefits or assistance (or the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds; or

(B) any Federal or State laws relating to taxation.

(Aug. 14, 1935, ch. 531, title XVIII, §1899, as added and amended Pub. L. 111–148, title III, §3022, title X, §10307, Mar. 23, 2010, 124 Stat. 395, 940; Pub. L. 114–255, div. C, title XVII, §17007, Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–123, div. E, title III, §§50324(a), 50331, 50341(a), Feb. 9, 2018, 132 Stat. 203, 205, 206.)

Editorial Notes

AMENDMENTS

2018—Subsec. (b)(2)(I). Pub. L. 115–123, §50341(a)(1), added subpar. (I).

Subsec. (c). Pub. L. 115–123, §50331, designated existing provisions as par. (1), inserted heading, substituted ''Subject to paragraph (2), the Secretary'' for ''The Secretary'', redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, and added par. (2).

Subsec. (e). Pub. L. 115–123, §50341(a)(3), inserted '', including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''the program''.

Subsec. (g)(6). Pub. L. 115–123, §50341(a)(4), inserted ''or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''under subsection (d)(4)''.

Subsec. (*l*). Pub. L. 115–123, § 50324(a), added subsec. (*l*).
Subsec. (m). Pub. L. 115–123, § 50341(a)(2), added subsec. (m).

2016—Subsec. (c). Pub. L. 114–255 substituted ''utilization of—'' for ''utilization of primary'', inserted par. (1) designation and ''in the case of performance years beginning on or after April 1, 2012, primary'' before ''care services'', and added par. (2).

2010—Subsecs. (i) to (k). Pub. L. 111–148, § 10307, added subsecs. (i) to (k).

Statutory Notes and Related Subsidiaries

STUDY AND REPORT

Pub. L. 115–123, div. E, title III, § 50324(b), Feb. 9, 2018, 132 Stat. 204, provided that:

''(1) STUDY.—

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study on the implementation of section 1899(*l*) of the Social Security Act [42 U.S.C. 1395jjj(*l*)], as added by subsection (a). Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

''(B) COLLECTION OF DATA.—The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

''(2) REPORT.—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''

§ 1395kkk. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(a), Feb. 9, 2018, 132 Stat. 298

Section, Aug. 14, 1935, ch. 531, title XVIII, § 1899A, as added and amended Pub. L. 111–148, title III, § 3403(a)(1), title X, § 10320(a), Mar. 23, 2010, 124 Stat. 489, 949, established the Independent Payment Advisory Board.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

Pub. L. 111–148, title X, § 10320(b), Mar. 23, 2010, 124 Stat. 952, which provided that any reference in the provisions of, or amendments made by, section 3403 of Pub. L. 111–148 (enacting this section and section 1395kkk–1 of this title and amending section 1395b–6 of this title and section 207 of Title 18, Crimes and Criminal Procedure) to the ''Independent Medicare Advisory Board'' be deemed to be a reference to the ''Independent Payment Advisory Board'', was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(4), Feb. 9, 2018, 132 Stat. 298.

CONSTRUCTION

Pub. L. 111–148, title X, § 10320(c), Mar. 23, 2010, 124 Stat. 952, which provided that nothing in the amendments made by section 10320 of Pub. L. 111–148 precluded the Independent Medicare Advisory Board (renamed the Independent Payment Advisory Board) from solely using data from public or private sources to carry out former subsection (f)(3)(B) of this section, was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(5), Feb. 9, 2018, 132 Stat. 298.

§ 1395kkk–1. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(b)(2), Feb. 9, 2018, 132 Stat. 298

Section, Pub. L. 111–148, title III, § 3403(b), Mar. 23, 2010, 124 Stat. 506, related to GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.

§ 1395*lll*. Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

(i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and

(ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms ''post-acute care provider'' and ''PAC provider'' mean—

(i) a home health agency;

(ii) a skilled nursing facility;

(iii) an inpatient rehabilitation facility; and

(iv) a long-term care hospital (other than a hospital classified under section 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term ''PAC assessment instrument'' means—

(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

(ii) in the case of skilled nursing facilities, the resident's assessment under section 1395i–3(b)(3) of this title;

(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary

assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and

(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term ''applicable reporting provision'' means—

(i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;

(ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;

(iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and

(iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term ''PAC payment system'' means—

(i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;

(ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;

(iii) with respect to an inpatient rehabilitation facility, the prospective payment system under section 1395ww(j) of this title; and

(iv) with respect to a long-term care hospital, the prospective payment system under section 1395ww(m) of this title.

(E) Specified application date

The term ''specified application date'' means the following:

(i) Quality measures

In the case of quality measures under subsection (c)(1)—

(I) with respect to the domain described in subsection (c)(1)(A) (relating to functional status, cognitive function, and changes in function and cognitive function)—

(aa) for PAC providers described in clauses (ii) and (iii) of paragraph (2)(A), October 1, 2016;

(bb) for PAC providers described in clause (iv) of such paragraph, October 1, 2018; and

(cc) for PAC providers described in clause (i) of such paragraph, January 1, 2019;

(II) with respect to the domain described in subsection (c)(1)(B) (relating to skin integrity and changes in skin integrity)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2017;

(III) with respect to the domain described in subsection (c)(1)(C) (relating to medication reconciliation)—

(aa) for PAC providers described in clause (i) of such paragraph, January 1, 2017; and

(bb) for PAC providers described in clauses (ii), (iii), and (iv) of such paragraph, October 1, 2018;

(IV) with respect to the domain described in subsection (c)(1)(D) (relating to incidence of major falls)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019; and

(V) with respect to the domain described in subsection (c)(1)(E) (relating to accurately communicating the existence of and providing for the transfer of health information and care preferences)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2018; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019.

(ii) Resource use and other measures

In the case of resource use and other measures under subsection (d)(1)—

(I) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(II) for PAC providers described in clause (i) of such paragraph, January 1, 2017.

(F) Medicare beneficiary

The term ''Medicare beneficiary'' means an individual entitled to benefits under part A or, as appropriate, enrolled for benefits under part B.

(b) Standardized patient assessment data

(1) Requirement for reporting assessment data

(A) In general

Beginning not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A) and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall require PAC providers to submit to the Secretary, under the applicable reporting provisions and through the use of PAC assessment instruments, the standardized patient assessment data described in subparagraph (B). The Secretary shall require such data be submitted with respect to admission and discharge of an individual (and may be submitted more frequently as the Secretary deems appropriate).

(B) Standardized patient assessment data described

For purposes of subparagraph (A), the standardized patient assessment data described in this subparagraph is data required

for at least the quality measures described in subsection (c)(1) and that is with respect to the following categories:

(i) Functional status, such as mobility and self care at admission to a PAC provider and before discharge from a PAC provider.

(ii) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

(iii) Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition.

(iv) Medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers.

(v) Impairments, such as incontinence and an impaired ability to hear, see, or swallow.

(vi) Other categories deemed necessary and appropriate by the Secretary.

(2) Alignment of claims data with standardized patient assessment data

To the extent practicable, not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A), and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall match claims data with assessment data pursuant to this section for purposes of assessing prior service use and concurrent service use, such as antecedent hospital or PAC provider use, and may use such matched data for such other uses as the Secretary determines appropriate.

(3) Replacement of certain existing data

In the case of patient assessment data being used with respect to a PAC assessment instrument that duplicates or overlaps with standardized patient assessment data within a category described in paragraph (1), the Secretary shall, as soon as practicable, revise or replace such existing data with the standardized data.

(4) Clarification

Standardized patient assessment data submitted pursuant to this subsection shall not be used to require individuals to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(c) Quality measures

(1) Requirement for reporting quality measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data described in subsection (b)(1) and other necessary data specified by the Secretary. Such measures shall be with respect to at least the following domains:

(A) Functional status, cognitive function, and changes in function and cognitive function.

(B) Skin integrity and changes in skin integrity.

(C) Medication reconciliation.

(D) Incidence of major falls.

(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions—

(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or

(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.

(2) Reporting through PAC assessment instruments

(A) In general

To the extent possible, the Secretary shall require such reporting by a PAC provider of quality measures under paragraph (1) through the use of a PAC assessment instrument and shall modify such PAC assessment instrument as necessary to enable the use of such instrument with respect to such quality measures.

(B) Limitation

The Secretary may not make significant modifications to a PAC assessment instrument more than once per calendar year or fiscal year, as applicable, unless the Secretary publishes in the Federal Register a justification for such significant modification.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the quality measures under this subsection taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such quality measures shall be risk adjusted, as determined appropriate by the Secretary.

(d) Resource use and other measures

(1) Requirement for resource use and other measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify resource use and other measures on which PAC providers are required under the applicable reporting provisions to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data. Such measures shall be with respect to at least the following domains:

(A) Resource use measures, including total estimated Medicare spending per beneficiary.

(B) Discharge to community.

(C) Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

(2) Aligning methodology adjustments for resource use measures

(A) Period of time

With respect to the period of time used for calculating measures under paragraph (1)(A), the Secretary shall, to the extent the Secretary determines appropriate, align resource use with the methodology used for purposes of section 1395ww(*o*)(2)(B)(ii) of this title.

(B) Geographic and other adjustments

The Secretary shall standardize measures with respect to the domain described in paragraph (1)(A) for geographic payment rate differences and payment differentials (and other adjustments, as applicable) consistent with the methodology published in the Federal Register on August 18, 2011 (76 Fed. Reg. 51624 through 51626), or any subsequent modifications made to the methodology.

(C) Medicare spending per beneficiary

The Secretary shall adjust, as appropriate, measures with respect to the domain described in paragraph (1)(A) for the factors applied under section 1395ww(*o*)(2)(B)(ii) of this title.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the resource use and other measures specified under this subsection with respect to the domain described in paragraph (1)(A), taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such resource use and other measures shall be risk adjusted, as determined appropriate by the Secretary.

(e) Measurement implementation phases; selection of quality measures and resource use and other measures

(1) Measurement implementation phases

In the case of quality measures specified under subsection (c)(1) and resource use and other measures specified under subsection (d)(1), the provisions of this section shall be implemented in accordance with the following phases:

(A) Initial implementation phase

The initial implementation phase, with respect to such a measure, shall, in accordance with subsections (c) and (d), as applicable, consist of—

(i) measure specification, including informing the public of the measure's numerator, denominator, exclusions, and any other aspects the Secretary determines necessary;

(ii) data collection, including, in the case of quality measures, requiring PAC providers to report data elements needed to calculate such a measure; and

(iii) data analysis, including, in the case of resource use and other measures, the use of claims data to calculate such a measure.

(B) Second implementation phase

The second implementation phase, with respect to such a measure, shall consist of the provision of feedback reports to PAC providers, in accordance with subsection (f).

(C) Third implementation phase

The third implementation phase, with respect to such a measure, shall consist of public reporting of PAC providers' performance on such measure in accordance with subsection (g).

(2) Consensus-based entity

(A) In general

Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(3) Treatment of application of pre-rulemaking process (measure applications partnership process)

(A) In general

Subject to subparagraph (B), the provisions of section 1395aaa–1 of this title shall apply in the case of a quality measure specified under subsection (c) or a resource use or other measure specified under subsection (d).

(B) Exceptions

(i) Expedited procedures

For purposes of satisfying subparagraph (A), the Secretary may use expedited procedures, such as ad-hoc reviews, as necessary, in the case of a quality measure specified under subsection (c) or a resource use or other measure specified in subsection (d) required with respect to data submissions under the applicable reporting provisions during the 1-year period before the specified application date applicable to such a measure and provider involved.

(ii) Option to waive provisions

The Secretary may waive the application of the provisions of section 1395aaa–1 of this title in the case of a quality measure or resource use or other measure described in clause (i), if the application of such provisions (including through the use of an expedited procedure described in such clause) would result in the inability of the Secretary to satisfy any deadline specified in this section with respect to such measure.

(f) Feedback reports to PAC providers

(1) In general

Beginning one year after the specified application date, as applicable to PAC providers and quality measures and resource use and other measures under this section, the Secretary shall provide confidential feedback reports to such PAC providers on the performance of such providers with respect to such measures required under the applicable provisions.

(2) Frequency

To the extent feasible, the Secretary shall provide feedback reports described in paragraph (1) not less frequently than on a quarterly basis. Notwithstanding the previous sentence, with respect to measures described in such paragraph that are reported on an annual basis, the Secretary may provide such feedback reports on an annual basis.

(g) Public reporting of PAC provider performance

(1) In general

Subject to the succeeding paragraphs of this subsection, the Secretary shall provide for public reporting of PAC provider performance on quality measures under subsection (c)(1) and the resource use and other measures under subsection (d)(1), including by establishing procedures for making available to the public information regarding the performance of individual PAC providers with respect to such measures.

(2) Opportunity to review

The procedures under paragraph (1) shall ensure, including through a process consistent with the process applied under section 1395ww(b)(3)(B)(viii)(VII) of this title for similar purposes, that a PAC provider has the opportunity to review and submit corrections to the data and information that is to be made public with respect to the provider prior to such data being made public.

(3) Timing

Such procedures shall provide that the data and information described in paragraph (1), with respect to a measure and PAC provider, is made publicly available beginning not later than two years after the specified application date applicable to such a measure and provider.

(4) Coordination with existing programs

Such procedures shall provide that data and information described in paragraph (1) with respect to quality measures and resource use and other measures under subsections (c)(1) and (d)(1) shall be made publicly available consistent with the following provisions:

(A) In the case of home health agencies, section 1395fff(b)(3)(B)(v)(III) of this title.

(B) In the case of skilled nursing facilities, sections 1395i–3(i) and 1396r(i) of this title.

(C) In the case of inpatient rehabilitation facilities, section 1395ww(j)(7)(E) of this title.

(D) In the case of long-term care hospitals, section 1395ww(m)(5)(E) of this title.

(h) Removing, suspending, or adding measures

(1) In general

The Secretary may remove, suspend, or add a quality measure or resource use or other measure described in subsection (c)(1) or (d)(1), so long as, subject to paragraph (2), the Secretary publishes in the Federal Register (with a notice and comment period) a justification for such removal, suspension, or addition.

(2) Exception

In the case of such a quality measure or resource use or other measure for which there is a reason to believe that the continued collection of such measure raises potential safety concerns or would cause other unintended consequences, the Secretary may promptly suspend or remove such measure and satisfy paragraph (1) by publishing in the Federal Register a justification for such suspension or removal in the next rulemaking cycle following such suspension or removal.

(i) Use of standardized assessment data, quality measures, and resource use and other measures to inform discharge planning and incorporate patient preference

(1) In general

Not later than January 1, 2016, and periodically thereafter (but not less frequently than once every 5 years), the Secretary shall promulgate regulations to modify conditions of participation and subsequent interpretive guidance applicable to PAC providers, hospitals, and critical access hospitals. Such regulations and interpretive guidance shall require such providers to take into account quality, resource use, and other measures under the applicable reporting provisions (which, as available, shall include measures specified under subsections (c) and (d), and other relevant measures) in the discharge planning process. Specifically, such regulations and interpretive guidance shall address the settings to which a patient may be discharged in order to assist subsection (d) hospitals, critical access hospitals, hospitals described in section 1395ww(d)(1)(B)(v) of this title, PAC providers, patients, and families of such patients with discharge planning from inpatient settings, including such hospitals, and from PAC provider settings. In addition, such regulations and interpretive guidance shall include procedures to address—

(A) treatment preferences of patients; and

(B) goals of care of patients.

(2) Discharge planning

All requirements applied pursuant to paragraph (1) shall be used to help inform and mandate the discharge planning process.

(3) Clarification

Such regulations shall not require an individual to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(j) Stakeholder input

Before the initial rulemaking process to implement this section, the Secretary shall allow

for stakeholder input, such as through town halls, open door forums, and mail-box submissions.

(k) Funding

For purposes of carrying out this section, the Secretary shall provide for the transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, of $130,000,000. Fifty percent of such amount shall be available on October 6, 2014, and fifty percent of such amount shall be equally proportioned for each of fiscal years 2015 through 2019. Such sums shall remain available until expended.

(*l*) Limitation

There shall be no administrative or judicial review under sections 1395ff and 1395*oo* of this title or otherwise of the specification of standardized patient assessment data required, the determination of measures, and the systems to report such standardized data under this section.

(m) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 (commonly referred to as the ''Paperwork Reduction Act of 1995'') shall not apply to this section and the sections referenced in subsection (a)(2)(B) that require modification in order to achieve the standardization of patient assessment data.

(Aug. 14, 1935, ch. 531, title XVIII, §1899B, as added Pub. L. 113–185, §2(a), Oct. 6, 2014, 128 Stat. 1952; amended Pub. L. 114–255, div. C, title XV, §15008(d)(1), Dec. 13, 2016, 130 Stat. 1321.)

Editorial Notes

REFERENCES IN TEXT

Section 2(d) of the IMPACT Act of 2014, referred to in subsecs. (c)(3)(A) and (d)(3)(A), is section 2(d) of Pub. L. 113–185, which is set out as a note under this section.

AMENDMENTS

2016—Subsec. (a)(2)(A)(iv). Pub. L. 114–255 substituted ''1395ww(d)(1)(B)(vi)'' for ''1395ww(d)(1)(B)(iv)(II)''.

Statutory Notes and Related Subsidiaries

PERMITTING OCCUPATIONAL THERAPISTS TO CONDUCT THE INITIAL ASSESSMENT VISIT AND COMPLETE THE COMPREHENSIVE ASSESSMENT WITH RESPECT TO CERTAIN REHABILITATION SERVICES FOR HOME HEALTH AGENCIES UNDER THE MEDICARE PROGRAM

Pub. L. 116–260, div. CC, title I, §115, Dec. 27, 2020, 134 Stat. 2948, provided that: ''Not later than January 1, 2022, the Secretary of Health and Human Services shall revise subsections (a)(2) and (b)(3) of section 484.55 of title 42, Code of Federal Regulations, or a successor regulation, to permit an occupational therapist to conduct the initial assessment visit and to complete the comprehensive assessment (as such terms are described in such subsections, respectively) for home health services for an individual under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) if the home health plan of care for such individual—

''(1) does not initially include skilled nursing care;

''(2) includes occupational therapy; and

''(3) includes physical therapy or speech language pathology.''

IMPROVING PAYMENT ACCURACY UNDER THE PAC PAYMENT SYSTEMS AND OTHER MEDICARE PAYMENT SYSTEMS

Pub. L. 113–185, §2(d), Oct. 6, 2014, 128 Stat. 1966, provided that:

''(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE.—

''(A) STUDY USING EXISTING MEDICARE DATA.—

''(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study that examines the effect of individuals' socioeconomic status on quality measures and resource use and other measures for individuals under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid under title XIX of such Act (42 U.S.C. 1396 et seq.) (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

''(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall submit to Congress a report on the study conducted under clause (i).

''(B) STUDY USING OTHER DATA.—

''(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and Medicare beneficiary activation, on quality measures and resource use and other measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

''(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

''(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

''(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality measures and resource use and other measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

''(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

''(ii) account for such factors—

''(I) in quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (including such measures specified under subsections (c) and (d) of section 1899B

of such Act [42 U.S.C. 1395*lll*], as added by subsection (a)); and

''(II) in determining payment adjustments based on such measures in other applicable provisions of such title.

''(E) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $6,000,000, to remain available until expended.

''(2) CMS ACTIVITIES.—

''(A) IN GENERAL.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1) and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other factors—

''(i) assess appropriate adjustments to quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including measures specified in subsections (c) and (d) of section 1899B of such Act, as added by subsection (a)); and

''(ii) assess and implement appropriate adjustments to payments under such title based on measures described in clause (i).

''(B) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

''(C) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in subparagraph (A) so as to monitor changes in possible relationships.

''(D) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $10,000,000, to remain available until expended.

''(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures under subsections (c) and (d) of section 1899B of the Social Security Act, as added by subsection (a), and, as the Secretary determines appropriate, other similar provisions of, including payment adjustments under, title XVIII of such Act (42 U.S.C. 1395 et seq.).''

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396. Medicaid and CHIP Payment and Access Commission

(a) Establishment

There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) Duties

(1) Review of access policies for all States and annual reports

MACPAC shall—

(A) review policies of the Medicaid program established under this subchapter (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under subchapter XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed

Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies

Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) Eligibility policies

Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) Enrollment and retention processes

Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) Coverage policies

Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require