(A) are from entities that manufacture pharmaceutical, biotechnology, medical device, or diagnostic products that are covered or for which coverage is being sought under this subchapter; and

(B) are with respect to coverage, coding, or payment under this subchapter for such products.

(2) Application

The second sentence of subsection (c)(2) shall apply to the ombudsman under subparagraph (A) in the same manner as such sentence applies to the Medicare Beneficiary Ombudsman under subsection (c).

(e) Funding for implementation of beneficiary enrollment simplification

For purposes of carrying out the provisions of and the amendments made by section 120 of division CC of the Consolidated Appropriations Act, 2021, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in such proportion as the Secretary determines appropriate), to the Centers for Medicare & Medicaid Services Program Management Account, of $2,000,000 for each of fiscal years 2021 through 2030, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, § 1808, as added and amended Pub. L. 108–173, title IX, §§ 900(a), (b), 923(a), Dec. 8, 2003, 117 Stat. 2369, 2393; Pub. L. 114–255, div. A, title IV, § 4010, Dec. 13, 2016, 130 Stat. 1185; Pub. L. 116–260, div. CC, title I, § 120(b), Dec. 27, 2020, 134 Stat. 2955.)

Editorial Notes

REFERENCES IN TEXT

Section 120 of division CC of the Consolidated Appropriations Act, 2021, referred to in subsec. (e), is section 120 of div. CC of Pub. L. 116–260, which amended this section and sections 1395i–2a, 1395p, 1395q, and 1395r of this title.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116–260 added subsec. (e).
2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).
2003—Subsec. (b). Pub. L. 108–173, § 900(b), added subsec. (b).
Subsec. (c). Pub. L. 108–173, § 923(a), added subsec. (c).

Statutory Notes and Related Subsidiaries

DEADLINE FOR APPOINTMENT

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

§ 1395b–10. Addressing health care disparities

(a) Evaluating data collection approaches

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

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this subchapter.

(3) Improving Medicare program data on race, ethnicity, and gender.

(b) Reports to Congress

(1) Report on evaluation

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

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

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

(2) Reports on data analyses

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

(c) Implementing effective approaches

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

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

PART A—HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426–1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government

employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

(Aug. 14, 1935, ch. 531, title XVIII, § 1811, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 92–603, title II, § 201(a)(2), Oct. 30, 1972, 86 Stat. 1371; Pub. L. 95–292, § 4(a), June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title I, § 103(a)(2), June 9, 1980, 94 Stat. 444; Pub. L. 96–473, § 2(b), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96–499, title IX, § 930(a), Dec. 5, 1980, 94 Stat. 2631; Pub. L. 97–248, title I, § 122(a)(1), title II, § 278(b)(3), Sept. 3, 1982, 96 Stat. 356, 561; Pub. L. 99–272, title XIII, § 13205(b)(2)(C)(i), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100–360, title I, § 104(d)(1), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979.)

Editorial Notes

AMENDMENTS

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

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

1986—Pub. L. 99–272 substituted ''government employment'' for ''Federal employment'' in cls. (1) and (2).

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

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

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

Pub. L. 96–473 substituted ''are eligible for'' for ''are entitled to''.

Pub. L. 96–265 substituted ''not less than 24 months'' for ''not less than 24 consecutive months''.

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1989 AMENDMENT

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

EFFECTIVE DATE OF 1988 AMENDMENT

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

EFFECTIVE DATE OF 1986 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

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

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

EFFECTIVE DATE OF 1978 AMENDMENT

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

DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM

Pub. L. 115–271, title VI, § 6092, Oct. 24, 2018, 132 Stat. 3999, provided that:

''(a) IN GENERAL.—Not later than July 1, 2019, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

''(b) CONSULTATION.—In developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

''(1) medical professional organizations;

''(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

''(3) health care consumers or groups representing such consumers; and

''(4) other entities determined appropriate by the Secretary.

''(c) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection, the following:

''(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—

''(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;

''(B) ways to prevent, recognize, and treat opioid overdoses; and

''(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

''(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

''(A) the adverse effects of prolonged opioid use;

''(B) non-opioid, evidence-based, non-pharmacological pain management treatments;

''(C) monitoring programs for individuals who have been prescribed opioids; and

''(D) the prescribing of naloxone along with an initial opioid prescription.

''(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include use of the notification template described in paragraph (4)).

''(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

''(A) explains the risks and side effects associated with opioid use (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;

''(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;

''(C) encourages such individuals to talk to their health care providers about such alternatives;

''(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual's behalf, to acknowledge receipt of such notification template;

''(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and

''(F) includes any other information determined appropriate by the Secretary.

''(5) Best practices for such hospital to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

''(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;

''(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;

''(C) strategies to reduce long-term opioid prescriptions; and

''(D) methods to identify such practitioners who may be over-prescribing opioids.

''(6) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.''

ADVISORY COUNCIL TO STUDY COVERAGE OF DISABLED UNDER THIS SUBCHAPTER

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

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

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

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

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

''(2) the hospital (A) meets the requirements of paragraphs (5) and (7) of section 1861(e) of such Act [42 U.S.C. 1395x(e)(5), (7)], (B) is not primarily engaged in providing the services described in section 1961(j)(1)(A) of such Act [42 U.S.C. 1395x(j)(1)(A)], and (C) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) of such Act [42 U.S.C. 1395x(r)(1)], to inpatients (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

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

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

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

''(1) prior to July 1, 1966,

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

''(3) for more than—

''(A) 90 days in any spell of illness, but only if (i) prior to January 1, 1969, the hospital furnishing

such services entered into an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] and (ii) the hospital's plan for utilization review, as provided for in section 1861(k) of such Act [42 U.S.C. 1395x(k)], has, in accordance with section 1814 of such Act [42 U.S.C. 1395f], been applied to the services furnished such individual, or

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

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

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

''(d) For the purposes of this section—

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

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

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

§ 1395d. Scope of benefits

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

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

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

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

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

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

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

(A) consist of—

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

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

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

(b) Services not covered

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

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

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

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

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