

(f) Multipayer strategy

In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applied under the Program under subsection (e)(2)(C). The Secretary may enter into a memorandum of understanding with other payers to align the methodology for payment provided by such a payer related to opioid use disorder treatment services with such methodology for payment under the Program.

(g) Evaluation**(1) In general**

The Secretary shall conduct an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program.

(2) Reports

The Secretary shall submit to Congress—

(A) a report with respect to the intermediate evaluation under paragraph (1) not later than 3 years after the date of the implementation of the Program; and

(B) a report with respect to the final evaluation under paragraph (1) not later than 6 years after such date.

(h) Funding**(1) Administrative funding**

For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), \$5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(2) Care management fees and incentives

For the purposes of making payments under subsection (e), \$10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title for each of fiscal years 2021 through 2024.

(3) Availability

Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Waivers

The Secretary may waive any provision of this subchapter as may be necessary to carry out the Program under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1866F, as added Pub. L. 115–271, title VI, §6042, Oct. 24, 2018, 132 Stat. 3979; amended Pub. L. 117–215, title I, §103(b)(4)(C), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(7), Dec. 29, 2022, 136 Stat. 5682.)

Editorial Notes**REFERENCES IN TEXT**

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (c)(1)(A)(i)(VII), is section 223 of Pub. L. 113–93, which is set out as a note under section 1396a of this title.

AMENDMENTS

2022—Subsec. (c)(3)(C). Pub. L. 117–328 struck out subpar. (C) which read as follows: “has in effect a waiver

in accordance with section 823(h) of title 21 for such purpose and is otherwise in compliance with regulations promulgated by the Substance Abuse and Mental Health Services Administration to carry out such section.”

Pub. L. 117–215 substituted “823(h)” for “823(g)”.

§ 1395cc–7. Extension of Acute Hospital Care at Home initiative**(a) In general****(1) Extension**

With respect to inpatient hospital admissions occurring during the period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title and ending on March 31, 2025, the Secretary of Health and Human Services shall grant waivers and flexibilities (as described in paragraph (2)) to an individual hospital that submits a request for such waivers and flexibilities and meets specified criteria (as described in paragraph (3)) in order to participate in the Acute Hospital Care at Home initiative of the Secretary.

(2) Acute Hospital Care at Home waivers and flexibilities

For the purposes of paragraph (1), the waivers and flexibilities described in this paragraph are the following waivers and flexibilities that were made available to individual hospitals under the Acute Hospital Care at Home initiative of the Secretary during the emergency period described in section 1320b–5(g)(1)(B) of this title:

(A) Subject to paragraph (3)(D), waiver of the requirements to provide 24-hour nursing services on premises and for the immediate availability of a registered nurse under section 482.23(b) of title 42, Code of Federal Regulations (or any successor regulation), and the waivers of the physical environment and Life Safety Code requirements under section 482.41 of title 42, Code of Federal Regulations (or any successor regulation).

(B) Flexibility to allow a hospital to furnish inpatient services, including routine services, outside the hospital under arrangements, as described in Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals; Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID–19 (87 Fed. Reg. 71748 et seq.).

(C) Waiver of the telehealth requirements under clause (i)¹ of section 1395m(m)(4)(C) of this title, as amended by section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, such that the originating sites described in clause (ii) of such section shall include the

¹So in original. Probably should be “clause (iii)”. See References in Text note below.

home or temporary residence of the individual.

(D) Other waivers and flexibilities that, as of December 29, 2022, were in place for such initiative during such emergency period.

(3) Specified criteria

For purposes of paragraph (1), the specified criteria for granting such waivers and flexibilities to individual hospitals are:

(A) The hospital shall indicate to the Secretary the criteria it would use to ensure that hospital services be furnished only to an individual who requires an inpatient level of care, and shall require that a physician document in the medical record of each such individual that the individual meets such criteria.

(B) The hospital and any other entities providing services under arrangements with the hospital shall ensure that the standard of care to treat an individual at home is the same as the standard of care to treat such individual as an inpatient of the hospital.

(C) The hospital shall ensure that an individual is only eligible for services under paragraph (1) if the individual is a hospital inpatient or is a patient of the hospital's emergency department for whom the hospital determines that an inpatient level of care is required (as described in subparagraph (A)).

(D) The hospital shall meet all patient safety standards determined appropriate by the Secretary, in addition to those that otherwise apply to the hospital, except those for which the waivers and flexibilities under this subsection apply.

(E) The hospital shall provide to the Secretary, at a time, form and manner determined by the Secretary, any data and information the Secretary determines necessary to do the following:

(i) Monitor the quality of care furnished, and to the extent practicable, ensure the safety of individuals and analyze costs of such care.

(ii) Undertake the study described in subsection (b).

(F) The hospital meets such other requirements and conditions as the Secretary determines appropriate.

(4) Termination

The Secretary may terminate a hospital from participation in such initiative (and the waivers and flexibilities applicable to such hospital) if the Secretary determines that the hospital no longer meets the criteria described in paragraph (3).

(b) Study and report

(1) In general

The Secretary shall conduct a study to—

(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative of the Secretary to determine which individuals may be furnished services under such initiative; and

(B) analyze and compare, to the extent practicable—

(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates, hospital mortality rates, length of stay, infection rates, and patient experience of care;

(ii) clinical conditions treated and diagnosis-related groups of discharges from the inpatient setting and under the Acute Hospital Care at Home initiative;

(iii) costs incurred by furnishing care in the inpatient setting and through the Acute Hospital Care at Home initiative;

(iv) the quantity, mix and intensity of such services (such as in-person visits and virtual contacts with patients) furnished in the Acute Hospital Care at Home initiative and furnished in the inpatient setting; and

(v) socioeconomic information on beneficiaries treated under the initiative, including racial and ethnic data, income, and whether such beneficiaries are dually eligible for benefits under this subchapter and subchapter XIX.

(2) Report

Not later than September 30, 2024, the Secretary of Health and Human Services shall post on a website of the Centers for Medicare & Medicaid Services a report on the study conducted under paragraph (1).

(3) Funding

In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2023, out of any amounts in the Treasury not otherwise appropriated, \$5,000,000, to remain available until expended, for purposes of carrying out this subsection.

(c) Implementation

Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.

(d) Publicly available information

The Secretary shall, as feasible, make the information collected under subsections (a)(3)(E) and (b)(1) available on the Medicare.gov internet website (or a successor website).

(Aug. 14, 1935, ch. 531, title XVIII, §1866G, as added Pub. L. 117–328, div. FF, title IV, §4140, Dec. 29, 2022, 136 Stat. 5926; amended Pub. L. 118–158, div. C, title II, §3208, Dec. 21, 2024, 138 Stat. 1766.)

Editorial Notes

REFERENCES IN TEXT

Section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, referred to in subsec. (a)(2)(C), is section 4113(a) of div. FF of Pub. L. 117–328, which amended subsec. (m)(2)(B)(iii), (4)(C)(iii) of section 1395m of this title.

AMENDMENTS

2024—Subsec. (a)(1). Pub. L. 118–158 substituted “March 31, 2025” for “December 31, 2024”.

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been

stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that¹ based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

¹ So in original. Probably should be followed by a comma.