

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

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

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

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

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

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

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

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

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

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

“(B) if that individual begins a period of hospitalization (as defined in such section) during 1989 after the end of that spell of illness, the first period of hospitalization during 1989 that begins after that spell of illness shall be considered to be (for purposes of such section) the first period of hospitalization that begins during that year; and

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

PROMULGATION OF NEW DEDUCTIBLE

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

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

(a) Requirement of requests and certifications

Except as provided in subsections (d) and (g) and in section 1395mm of this title, payment for

services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if—

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

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

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

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

¹ So in original.

for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be); such services are or were furnished while the individual was under the care of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary; or

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

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in

accordance with clause (A) shall be furnished no later than the 20th day of such period;

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

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

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

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

(A)(i) in the first 90-day period—

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

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

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

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

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

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

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

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

(II) during the emergency period described in section 1320b-5(g)(1)(B) of this title, and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1320b-5(g)(1)(B) of this title and ending on December 31, 2024, a hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth, as determined appropriate by the Secretary; and

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

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

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

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

a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981 (or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020), and which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019 or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,¹ and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician, nurse practitioner, clinical nurse specialist, or physician assistant who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved. For purposes of paragraph (2)(C), an individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home”, the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be “confined to his home”. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infre-

quent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Amount paid to provider of services

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

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

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

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

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

(B) the aggregate rate of increase from January 1, 1981, to the most recent date for

which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system. For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title.

(c) No payments to Federal providers of services

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

(d) Payments for emergency hospital services

(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1395x(w) of

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

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

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 426 of this title for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

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

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

Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitle-

ment, if such payments are precluded only by reason of section 1395d of this title and if such hospital complies with the requirements of and regulations under this subchapter with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

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

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

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

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

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

(A) such individual was physically present—

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

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

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

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

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

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 426 of this title may be made on the basis of an itemized bill to such indi-

vidual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1395e of this title, be equal to the amount which would be payable under subsection (d)(3).

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

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

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

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

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

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

(2) Payment for services described in paragraph (1) shall be in an amount equal to the

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

(i) Payment for hospice care

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

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

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

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

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

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

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

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

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

(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase

for the fiscal year involved minus 1.0 percentage points, plus, in the case of fiscal year 2001, 5.0 percentage points; and

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

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

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

(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.3 percentage point.

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

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

(I) the excess (if any) of—

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

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

(II) 5 percentage points.

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

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

beneficiaries in the hospice program in that year (determined under subparagraph (C)).

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

(ii) For purposes of subparagraph (A) for accounting years that end after September 30, 2016, and before October 1, 2032, the “cap amount” is the cap amount under this subparagraph for the preceding accounting year updated by the percentage update to payment rates for hospice care under paragraph (1)(C) for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year (including the application of any productivity or other adjustment under clause (iv) of that paragraph).

(iii) For accounting years that end after September 30, 2032, the cap amount shall be computed under clause (i) as if clause (ii) had never applied.

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

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

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

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

(5) QUALITY REPORTING.—

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

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the

case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of clauses (iv) and (vi) of paragraph (1)(C), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points (or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points).

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

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

(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) Payment for inpatient critical access hospital services

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

(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1395i-4(c)(2)(E) of this title, the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v)³ of section 1395ww(d)(1)(B) of this title.

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

was treated as an eligible hospital under such section:

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

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

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

(II) 20 percentage points.

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

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

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

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

(B) The percent described in this subparagraph is—

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

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

³ See References in Text note below.

such subclause applies with respect to subclause (I) of such section for a subsection (d) hospital with respect to such fiscal year.

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

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

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

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

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

(Aug. 14, 1935, ch. 531, title XVIII, § 1814, as added Pub. L. 89–87, title I, § 102(a), July 30, 1965, 79 Stat. 294; amended Pub. L. 90–248, title I, §§ 126(a), 129(c)(5), (6)(A), 143(c), Jan. 2, 1968, 81 Stat. 846, 848, 857; Pub. L. 92–603, title II, §§ 211(a), 226(c)(1), 227(b), 228(a), 233(a), 234(g)(1), 238(a), 247(a), 256(a), 278(a)(1)–(3), (b)(4), (17), 281(e), Oct. 30, 1972, 86 Stat. 1382, 1404, 1405, 1407, 1411, 1413, 1416, 1425, 1447, 1453, 1454, 1456; Pub. L. 93–233, § 18(k)(1), (2), Dec. 31, 1973, 87 Stat. 970; Pub. L. 94–437, title IV, § 401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 95–142, § 23(a), (b), Oct. 25, 1977, 91 Stat. 1208; Pub. L. 95–292, § 4(f), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§ 903(a), 930(e), (f), 931(b), 936(b), 941(a), (b), Dec. 5, 1980, 94 Stat. 2614, 2631, 2633, 2640, 2641; Pub. L. 97–35, title XXI, §§ 2121(b), 2122(a)(1), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§ 101(c)(1), 122(c)(1), (2), Sept. 3, 1982, 96 Stat. 335, 357, 358; Pub. L. 97–448, title III, § 309(b)(7), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§ 601(d), 602(b), (c), Apr. 20, 1983, 97 Stat. 152, 163; Pub. L. 98–90, Aug. 29, 1983, 97 Stat. 606; Pub. L. 98–369, div. B, title III, §§ 2308(b)(2)(A), 2321(a), (f), 2335(a), 2336(a), (b), 2354(b)(1), (c)(1)(A), July 18, 1984, 98 Stat. 1074, 1084, 1085, 1090, 1091, 1100, 1102; Pub. L. 98–617, § 1(a), 3(a)(3), (b)(1), Nov. 8, 1984, 98 Stat. 3294, 3295; Pub. L. 99–272, title IX, § 9123(b), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, §§ 4008(b)(1), 4024(a), 4062(d)(1), Dec. 22, 1987, 101 Stat. 1330–55, 1330–73, 1330–108; Pub. L. 100–360, title I, § 104(d)(2), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title VI, §§ 6003(g)(3)(B)(ii), (iii), 6005(a), (b), 6028, Dec. 19, 1989, 103 Stat. 2152, 2160, 2161, 2168; Pub. L. 101–508, title IV, §§ 4006(b), 4008(i)(3), (m)(3)(A), Nov. 5, 1990, 104 Stat. 1388–43, 1388–51, 1388–53; Pub. L. 102–54, § 13(q)(3)(A)(iii), (iv), (B)(iv), June 13, 1991, 105 Stat. 279; Pub. L. 103–66, title XIII, § 13504, Aug. 10, 1993, 107 Stat. 579; Pub. L. 103–432, title I, §§ 102(a)(3), (d),

106(b)(1)(A), 110(d)(1), Oct. 31, 1994, 108 Stat. 4402, 4403, 4405, 4408; Pub. L. 105–33, title IV, §§ 4201(c)(1), (3), 4441, 4442(a), 4443(b)(2), 4448, 4603(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 422–424, 470, 475; Pub. L. 106–554, § 1(a)(6) [title III, §§ 321(a), (e), 322(a)(1), title V, § 507(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, 2763A–501, 2763A–532; Pub. L. 108–173, title IV, §§ 405(a)(1), (g)(2), 408(b), title V, § 512(b), title VII, § 736(a)(1), (2), (c)(2)(A), title IX, § 946(b), Dec. 8, 2003, 117 Stat. 2266, 2269, 2270, 2299, 2354, 2356, 2425; Pub. L. 111–5, div. B, title IV, § 4102(a)(2), (b)(2), (d)(1), Feb. 17, 2009, 123 Stat. 481, 483, 486; Pub. L. 111–148, title III, §§ 3004(c), 3108(a), 3132, 3401(g), title VI, §§ 6404(a)(1), 6405(b)(1), 6407(a)(1), title X, §§ 10319(f), 10604, 10605(a), Mar. 23, 2010, 124 Stat. 370, 418, 430, 484, 767–769, 949, 1006; Pub. L. 113–185, § 3(c), (d), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title IV, § 411(d), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title X, §§ 51002(a), 51006(a)(2), Feb. 9, 2018, 132 Stat. 292, 296; Pub. L. 116–136, div. A, title III, §§ 3706, 3708(a), Mar. 27, 2020, 134 Stat. 418; Pub. L. 116–260, div. CC, title IV, §§ 404, 407(b), Dec. 27, 2020, 134 Stat. 3002, 3008; Pub. L. 117–103, div. P, title II, §§ 306, 312, Mar. 15, 2022, 136 Stat. 807, 808; Pub. L. 117–328, div. FF, title IV, §§ 4113(f), 4162, Dec. 29, 2022, 136 Stat. 5899, 5931.)

Editorial Notes

REFERENCES IN TEXT

The amendments made by section 3708 of the CARES Act, referred to in subsec. (a), are the amendments made by section 3708 of Pub. L. 116–136, which amended this section and sections 1395n, 1395x, and 1395fff of this title.

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

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

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

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (l)(2), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, § 15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2022—Subsec. (a)(7)(D)(i)(II). Pub. L. 117–328, § 4113(f), substituted “and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1320b–5(g)(1)(B) of this title and ending on December 31, 2024” for “and during the 151-day period beginning on the first day after the end of such emergency period”.

Pub. L. 117–103, § 306, inserted “, and during the 151-day period beginning on the first day after the end of such emergency period” after “section 1320b–5(g)(1)(B) of this title”.

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 117–328, § 4162, substituted “2032” for “2031”.

Pub. L. 117–103, § 312, substituted “2031” for “2030”.

⁴ So in original. Probably should be “1395ww(n)(3)(B)”.

2020—Subsec. (a). Pub. L. 116-136, §3708(a)(4), in fourth sentence of concluding provisions, inserted “or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,” after “January 1, 2019” and “, nurse practitioner, clinical nurse specialist, or physician assistant” after “of the physician”.

Pub. L. 116-136, §3708(a)(3), in third sentence of concluding provisions, inserted “, nurse practitioner, clinical nurse specialist, or physician assistant” after “physician”.

Pub. L. 116-136, §3708(a)(2), in second sentence of concluding provisions, substituted “With respect to the certification” for “With respect to the physician certification” and “which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who” for “which prohibit a physician who” and inserted “(or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020)” after “July 1, 1981”.

Subsec. (a)(2). Pub. L. 116-136, §3708(a)(1)(A), in introductory provisions, inserted “, a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is” after “in the case of services described in subparagraph (C), a physician”.

Subsec. (a)(2)(C). Pub. L. 116-136, §3708(a)(1)(B), inserted “, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be)” after “reviewed by a physician” and after “care of a physician” and substituted “, and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter” for “, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter”.

Subsec. (a)(7)(D)(i). Pub. L. 116-136, §3706, designated existing provisions as subcl. (I), substituted “subject to subclause (II), a hospice” for “a hospice”, and added subcl. (II).

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 116-260, §404, substituted “2030” for “2025”.

Subsec. (i)(5)(A)(i). Pub. L. 116-260, §407(b), inserted “(or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points)” before period at end.

2018—Subsec. (a). Pub. L. 115-123, §51002(a), inserted “For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency

from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved.” before “For purposes of paragraph (2)(C),” in concluding provisions.

Subsec. (a)(7)(A)(i)(I). Pub. L. 115-123, §51006(a)(2), inserted “or a physician assistant” after “a nurse practitioner”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2000—Subsec. (a). Pub. L. 106-554, § 1(a)(6) [title V, § 507(a)(1)(B)], inserted at end “Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered

to be ‘confined to his home’. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.”

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(1) the lesser of—

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

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

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

“(2) if such equipment is furnished by a public home health agency, or by another home health agency

which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charge to the public, 80 percent of the amount which the Secretary finds will provide fair compensation to the home health agency."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (k)(2). Pub. L. 98-617, §3(b)(1), inserted " , or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant por-

tion of its patients are low-income (and requests that payment be made under this paragraph), after "public home health agency" and "80 percent of" before "the amount".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subsec. (f). Pub. L. 92-603, §211(a), designated existing provisions as par. (2), added pars. (1), (3), and (4), and in par. (2) as so redesignated inserted provisions covering individuals physically present at a place within Canada while traveling without unreasonable delay by the most direct route between Alaska and another State.

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

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

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

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

Subsec. (a)(2)(A) to (E). Pub. L. 90-248, §126(a)(1), (2), struck out subpar. (A) which provided that there be a physician’s certification of medical necessity for admissions to hospitals other than psychiatric or tuberculosis institutions, and redesignated subpars. (B) to (E) as (A) to (D), respectively.

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

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

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

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116-136, div. A, title III, §3708(f), Mar. 27, 2020, 134 Stat. 421, provided that: “The Secretary of Health and Human Services shall prescribe regulations to apply the amendments made by this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] to items and services furnished, which shall become effective no later than 6 months after the date of the enactment of this legislation [Mar. 27, 2020]. The Secretary shall promulgate an interim final rule if necessary, to comply with the required effective date.”

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115-123, div. E, title X, §51006(b), Feb. 9, 2018, 132 Stat. 296, provided that: “The amendments made by this section [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2019.”

EFFECTIVE DATE OF 2010 AMENDMENT

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

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

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

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

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

EFFECTIVE DATE OF 2003 AMENDMENT

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

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

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

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

EFFECTIVE DATE OF 2000 AMENDMENT

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

Pub. L. 106-554, § 1(a)(6) [title III, § 322(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-501, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Dec. 21, 2000].”

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

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

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

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

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

EFFECTIVE DATE OF 1994 AMENDMENT

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

EFFECTIVE DATE OF 1990 AMENDMENT

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

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-239, title VI, § 6005(c), Dec. 19, 1989, 103 Stat. 2161, as amended by Pub. L. 101-508, title IV,

§ 4008(m)(3)(B), Nov. 5, 1990, 104 Stat. 1388-54, provided that: “The amendments made by subsections (a) and (b) [amending this section] shall become effective with respect to care and services furnished on or after January 1, 1990.”

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

EFFECTIVE DATE OF 1988 AMENDMENT

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

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100-203, title IV, § 4008(b)(2), Dec. 22, 1987, 101 Stat. 1330-55, provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].”

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

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

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

EFFECTIVE DATE OF 1984 AMENDMENT

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

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

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

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

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

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

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

EFFECTIVE DATE OF 1983 AMENDMENT

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

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT

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

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

EFFECTIVE DATE OF 1980 AMENDMENT

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

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

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

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

EFFECTIVE DATE OF 1978 AMENDMENT

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

of Pub. L. 95-292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

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

EFFECTIVE DATE OF 1973 AMENDMENT

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

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92-603, title II, §211(d), Oct. 30, 1972, 86 Stat. 1384, provided that: "The amendments made by this section [amending this section and sections 1395i, 1395u, 1395x, and 1395y of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1972."

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

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

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

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

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

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

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

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

Amendment by section 281(e) of Pub. L. 92-603 applicable in the case of services furnished (or deemed to have been furnished) after 1970, see section 281(g) of

Pub. L. 92-603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

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

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

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

REVISION OF REGULATIONS REGARDING ACCESS TO HOME HEALTH SERVICES

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

PROMULGATION OF REGULATIONS

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

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

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

PROGRAM INSTRUCTION AUTHORITY

Pub. L. 117-328, div. FF, title IV, §4113(h), Dec. 29, 2022, 136 Stat. 5901, provided that: “Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, this section [amending this section and section 1395m of this title] through program instruction or otherwise.”

APPLICATION TO MEDICAID

Pub. L. 116-136, div. A, title III, §3708(e), Mar. 27, 2020, 134 Stat. 421, provided that: “The amendments made under this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] shall apply under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the same manner and to the same extent as such requirements apply under title XVIII of such Act [42 U.S.C. 1395 et seq.] or regulations promulgated thereunder.”

APPLICATION OF 2010 AMENDMENT

Pub. L. 111-148, title VI, §6405(c), Mar. 23, 2010, 124 Stat. 768, provided that: “The Secretary [probably means the Secretary of Health and Human Services] may extend the requirement applied by the amendments made by subsections (a) [amending section 1395m

of this title] and (b) [amending this section and section 1395n of this title] to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D-2(e) of such Act (42 U.S.C. 1395w-102[(e)]), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w-4(k)(3)(B)).”

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

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

STUDY AND REPORT ON EFFECT OF 2000 AMENDMENT

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

“(1) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the effect of the amendment [amending this section and section 1395n of this title] on the cost of and access to home health services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

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

STUDY AND REPORT ON PHYSICIAN CERTIFICATION REQUIREMENT FOR HOSPICE BENEFITS

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

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

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

TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE

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

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

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

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

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

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

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

Pub. L. 106-113, div. B, § 1000(a)(6) [title I, § 132], Nov. 29, 1999, 113 Stat. 1536, 1501A-333, provided that the Comptroller General of the United States would conduct a study, including cost factors, to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under subsec. (i) of this section for routine home care and other services included in hospice care, and provided the Comptroller General was to submit to Congress a report on the study together with any recommendations for legislation deemed appropriate not later than one year after Nov. 29, 1999.

STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE

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

CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES

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

the hospital's collection policy. Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply.”

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

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

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

Pub. L. 98-369, div. B, title III, § 2308(a), July 18, 1984, 98 Stat. 1074, provided that: “The Secretary of Health and Human Services shall issue regulations which require, for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], that providers of services calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h) [42 U.S.C. 1395f(h)]), and that payment under such title be based upon such separate determinations. Such regulations shall apply to cost reporting periods beginning on or after October 1, 1984.”

DETERMINATION OF NOMINAL CHARGES FOR APPLYING NOMINALITY TEST

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

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

Pub. L. 97-248, title I, § 122(j), formerly § 122(i), Sept. 3, 1982, 96 Stat. 363, as redesignated by Pub. L. 97-448, title III, § 309(a)(6), Jan. 12, 1983, 96 Stat. 2408, provided that the Secretary of Health and Human Services would conduct a study and, prior to January 1, 1986, report to the Congress on whether the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) were fair and equitable and promote the most efficient provision of hospice care.

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

Pub. L. 97-248, title I, § 122(k), formerly § 122(j), Sept. 3, 1982, 96 Stat. 363, as redesignated and amended by

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

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

Pub. L. 93-233, §16, Dec. 31, 1973, 87 Stat. 967, provided that: “In the administration of titles V, XVIII, and XIX of the Social Security Act [42 U.S.C. 701 et seq., 1395 et seq., 1396 et seq.], the amount payable under such title with respect to which the amendments made by section 233 of Public Law 92-603 [this section and sections 706, 709, 1395f, and 1396b of this title] would, except for the provisions of this section, be applicable) in like manner as if the date contained in the first and second sentences of subsection (f) of such section 233 [set out as an Effective Date of 1972 Amendment note above] were December 31, 1973, rather than December 31, 1972.”

§ 1395g. Payments to providers of services

(a) Determination of amount

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

(b) Conditions

No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1395x(w)(2) of this title, to have in effect an arrangement with a quality improvement organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this subchapter for utilization review activities provided by a qual-

ity improvement organization pursuant to an arrangement or deemed arrangement with a hospital under section 1395x(w)(2) of this title shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.

(c) Payments under assignment or power of attorney

No payment which may be made to a provider of services under this subchapter for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

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

Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments (or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b-5(g)(1)(B) of this title under the program under subsection (e)(3), including such program as expanded pursuant to subsection (f), at a rate of 4 percent).

(e) Periodic interim payments

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

(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1395h of this title, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets