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1395w–21(a)(2)(A) of this title’” in introductory provisions.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1395w–21, 1395w–22, 1395w–23 of this title; title 26 section 138.

PART D—MISCELLANEOUS PROVISIONS

PART REFERRED TO IN OTHER SECTIONS

This part is referred to in sections 426, 1395i–4 of this title; title 45 section 231f.

§ 1395x. Definitions

For purposes of this subchapter—

(a) Spell of illness

The term “spell of illness” with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A of this subchapter, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1396f(a)(2) of this title or subsection (y)(1) of this section.

(b) Inpatient hospital services

The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by such hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K) of this section, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this subchapter for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

(c) Inpatient psychiatric hospital services

The term “inpatient psychiatric hospital services” means inpatient hospital services furnished to an inpatient of a psychiatric hospital.


(e) Hospital

The term “hospital” (except for purposes of sections 1395f(d), 1395f(f), and 1395n(b) of this title, subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has bylaws in effect with respect to its staff of physicians;

(3) has a requirement that every patient with respect to whom payment may be made under this subchapter must be under the care of a physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii) of this section) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;

(4) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—
(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) of this section and (B) has in place a discharge planning process that meets the requirements of subsection (ee) of this section;

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (2) of this section; and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2) of this section, such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1395f(d) and 1395m(b) of this title (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1395f(f)(2) of this title, and subsection (i) of this section, such term includes any institution which (i) meets the requirements of subsection (k) of this section, (ii) is primarily engaged in providing the services described in subsection (j)(1)(A) of this section, (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of subsection (r) of this section, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1395f(f)(1) of this title, such term includes an institution which (i) is a hospital for purposes of sections 1395f(d), 1395f(f)(2), and 1395m(b) of this title and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2) of this section, include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f) of this section). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1) of this section), but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395–5 of this title. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1395sb of this title. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9),
the Secretary (i) may waive, for such period as
he deems appropriate, specific provisions of
such requirements which if rigidly applied
would result in unreasonable hardship for such
a facility and which, if not applied, would not
jeopardize the health and safety of patients,
and (ii) may accept a facility’s compliance
with all applicable State codes relating to fire
and safety in lieu of compliance with the fire
and safety requirements promulgated under
paragraph (9), if he determines that such State
has in effect fire and safety codes, imposed by
State law, which adequately protect patients.

The term “hospital” does not include, unless the
context otherwise requires, a critical access hos-
pital (as defined in subsection (mm)(1) of this
section).

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(f) Psychiatric hospital
The term “psychiatric hospital” means an in-
stitution which—
(1) is primarily engaged in providing, by or
under the supervision of a physician, psy-
chiatric services for the diagnosis and treat-
m ent of mentally ill persons;
(2) satisfies the requirements of paragraphs
(3) through (9) of subsection (e) of this section;
(3) maintains clinical records on all patients
and maintains such records as the Secretary
finds to be necessary to determine the degree
and intensity of the treatment provided to in-
dividuals entitled to hospital insurance bene-
fits under part A of this subchapter; and
(4) meets such staffing requirements as the
Secretary finds necessary for the institution
to carry out an active program of treatment
for individuals who are furnished services in
the institution.

In the case of an institution which satisfies
paragraphs (1) and (2) of the preceding sentence
and which contains a distinct part which also
satisfies paragraphs (3) and (4) of such sentence,
such distinct part shall be considered to be a
“psychiatric hospital”.

(g) Outpatient occupational therapy services
The term “outpatient occupational therapy
services” has the meaning given the term “out-
patient physical therapy services” in subsection
(f) of this section, except that “occupational”
shall be substituted for “physical” each place it
appears therein.

(h) Extended care services
The term “extended care services” means the
following items and services furnished to an
inpatient of a skilled nursing facility and (except
as provided in paragraphs (3), (6), and (7)) by
such skilled nursing facility—
(1) nursing care provided by or under the su-
 pervision of a registered professional nurse;
(2) bed and board in connection with the fur-
 nishing of such nursing care;
(3) physical or occupational therapy or
speech-language pathology services furnished
by the skilled nursing facility or by others
under arrangements with them made by the
facility;
(4) medical social services;
(5) such drugs, biologicals, supplies, appli-
cances, and equipment, furnished for use in the
skilled nursing facility, as are ordinarily fur-
nished by such facility for the care and treatment
of inpatients;
(6) medical services provided by an intern or
 resident-in-training of a hospital with which
the facility has in effect a transfer agreement
(meeting the requirements of subsection (f) of
this section), under a teaching program of
such hospital approved as provided in the last
sentence of subsection (b) of this section, and
other diagnostic or therapeutic services pro-
vided by a hospital with which the facility has
such an agreement in effect; and
(7) such other services necessary to the
health of the patients as are generally pro-
vided by skilled nursing facilities, or by others
under arrangements with them made by the
facility;

excluding, however, any item or service if it
would not be included under subsection (b) of
this section if furnished to an inpatient of a hos-
pital.

(i) Post-hospital extended care services
The term “post-hospital extended care serv-
ces” means extended care services furnished an
individual after transfer from a hospital in
which he was an inpatient for not less than 3
consecutive days before his discharge from the
hospital in connection with such transfer. For
purposes of the preceding sentence, items and
services shall be deemed to have been furnished
to an individual after transfer from a hospital,
and he shall be deemed to have been an inpa-
tient in the hospital immediately before trans-
fer therefrom, if he is admitted to the skilled
nursing facility, as are ordinarily fur-
nished by such facility for the care and treat-
ment of inpatients;

skilled nursing facility care would not be medi-
 cally appropriate to begin an active course of treatment, in the case
of an individual whose condition is such that
skilled nursing facility care would not be medi-
cally appropriate within 30 days after discharge from a hospital; and
an individual shall be
deemed not to have been discharged from a
skilled nursing facility if, within 30 days after dis-
charge from such hospital, or (B) within such
time as it would be medically appropriate to
dischARGE therefrom, he is admitted to such fa-

cility or any other skilled nursing facility.

(j) Skilled nursing facility
The term “skilled nursing facility” has the
meaning given such term in section 1395i–3(a) of
this title.

(k) Utilization review
A utilization review plan of a hospital or
skilled nursing facility shall be considered suffi-
cient if it is applicable to services furnished by
the institution to individuals entitled to insur-
ance benefits under this subchapter and if it pro-
vides—
(1) for the review, on a sample or other basis,
of admissions to the institution, the duration
of stays therein, and the professional services
(including drugs and biologicals) furnished, (A)
with respect to the medical necessity of the
services, and (B) for the purpose of promoting
the most efficient use of available health fa-
cilities and services;
(2) for such review to be made by either (A)
a staff committee of the institution composed
of two or more physicians (of which at least

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two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary:

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to subchapter XIX of this chapter are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this subchapter that the procedures established pursuant to subchapter XIX of this chapter be utilized instead of the procedures required by this section.

(i) Agreements for transfer between skilled nursing facilities and hospitals

A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1395aa of this title is in effect (or, in the case of a State in which no such agency has an agreement under section 1395aa of this title, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this subchapter.

(m) Home health services

The term “home health services” means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual’s home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk) of this section), but excluding other drugs and biologicals) and durable medical equipment while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b) of this section; and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

(8) home health services described in clauses (1), (2), (3), (4), (5), and (6) of section 1396d of this title, and

(9) home health services described in paragraphs (1) through (4) of section 1395aa of this title.
but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) of this section if furnished to an inpatient of a hospital. For purposes of paragraphs (1) and (4), the term “part-time or intermittent services” means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395f(a)(2)(C) and

The term “durable medical equipment” includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual’s medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient’s home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1395i–3(a)(1) of this title), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual’s use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations); except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

The term “home health agency” means a public agency or private organization, or a subdivision of such an agency or organization, which—

(a) is primarily engaged in providing skilled nursing services and other therapeutic services;

(b) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(c) maintains clinical records on all patients;

(d) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(e) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section;

(f) meets the conditions of participation specified in section 1395bbb(a) of this title and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

(g) provides the Secretary with a surety bond—

(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

(B) in a form specified by the Secretary; and

(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this subchapter and subchapter XIX of this chapter for that year, as estimated by the Secretary; and

(h) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program; except that for purposes of part A of this subchapter such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.

The term “outpatient physical therapy services” means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of subsection (r) of this section), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical
therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) of this section if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients;

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term “outpatient physical therapy services” also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual’s home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term “outpatient physical therapy services” also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this subchapter, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

(q) Physicians’ services

The term “physicians’ services” means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6) of this section).

(r) Physician

The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1391(a)(7) of this title), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) of this section and with respect to the provision of items or services described in subsection (s) of this section which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purposes of subsections (s)(1) and (s)(2)(A) of this section and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1395y(a)(4) of this title and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice medicine and surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6) of this section).
practice such art in the country in which the inpatient hospital services (referred to in such section 1395y(a)(4) of this title) are furnished.

(s) Medical and other health services

The term “medical and other health services” means any of the following items or services:

(1) physicians’ services;

(2) (A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in the physicians’ bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians’ services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in subsection (r)(1) of this section, for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H) services furnished pursuant to a contract under section 1395mm of this title to a member of an eligible organization by a physician assistant (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (aa)(5) of this section) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service; and

(i) services furnished pursuant to a contract under section 1395mm(g) of this title to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5) of this section) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician’s service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1395mm(g) of this title to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2) of this section), and such services and supplies furnished as an incident to such clinical psychologist’s services or clinical social worker’s services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician’s service;

(1) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(2) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this subchapter, but only in the case of drugs furnished—

(i) before 1995, within 12 months after the date of the transplant procedure,

(ii) during 1995, within 18 months after the date of the transplant procedure,

(iii) during 1996, within 24 months after the date of the transplant procedure,

(iv) during 1997, within 30 months after the date of the transplant procedure, and

(v) during any year after 1997, within 36 months after the date of the transplant procedure plus such additional number of months (if any) provided under section 1395k(b) of this title;

(K) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a physician assistant (as defined in subsection (aa)(5) of this section) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service; and

L certified nurse-midwife services;

(M) qualified psychologist services;

(N) clinical social worker services (as defined in subsection (hh)(2) of this section);

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such

1 So in original. The word “and” probably should not appear.

2 So in original. Probably should be followed by “and”.
drug, and items related to the administration of such drug;

(P) prostate cancer screening tests (as defined in subsection (oo) of this section);

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp) of this section); and

(S) diabetes outpatient self-management training services (as defined in subsection (qq) of this section); and

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician or as prescribed by a physician—

(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act [42 U.S.C. 263b]), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 407l(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb) of this section);

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj) of this section);

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr) of this section).

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title) shall be included within paragraph (3) unless such laboratory—

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 333 of the Public Health Service Act [42 U.S.C. 263a]; and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) of this section if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs
(other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1395f(d) of this title shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

(f) Drugs and biologicals

(1) The term “drugs” and the term “biologicals”, except for purposes of subsection (m)(5) of this section and paragraph (2), include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

For purposes of paragraph (2) of this subsection the term “drugs” also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), the term “medically accepted indication”, with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for use in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

The Secretary may revise the list of compendia in clause (ii)(I) as is appropriate for identifying medically accepted indications for drugs.

(u) Provider of services

The term “provider of services” means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395m(e) of this title, a fund.

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established payment organizations which have developed such principles in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determining the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and fees for services with respect to individuals not so covered will not be borne by insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) In the case of extended care services, the regulations under subparagraph (A) shall not include provision for specific recognition of a return on equity capital.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A of this subchapter, but only if—
(I) payment for such services as furnished under such arrangement would be made under part A of this subchapter to the hospital had such services been furnished by the hospital, and

(ii) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(iii) such payment may be made under part B of this subchapter, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) of this section or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) of this title, and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under subchapter XIX of this chapter (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this subchapter not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1395l-3 of this title (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1320a(a) of this title in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this subchapter at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this subchapter.

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under subchapter XIX of this chapter for the State in such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under subchapter XIX of this chapter, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this subchapter in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this subchapter for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this chapter (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hos-
pital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the surety bond requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section;

(ii) in the case of home health agencies to which the surety bond requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this subchapter to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this subchapter and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after December 5, 1980, and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expira-

ration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation3 criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.

(J) Such regulations may not provide for any reimbursement cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this subchapter.

(ii) For purposes of clause (i), the term “bona fide emergency services” means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;

(II) serious impairment to bodily functions; or

(III) serious dysfunction of any bodily organ or part.

(L)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies;

(II) July 1, 1986, and before July 1, 1987, 115 percent of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean,

3So in original. Probably should be "regulations".
(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies, or

(V) October 1, 1998, 106 percent of such median.

(ii) Effective for cost reporting periods beginning on or after July 1, 1996, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis. The Secretary may provide for such exceptions and exceptions to such limitation as he deems appropriate.

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1395ww(d)(3)(E) of this title and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1395ww(d)(8)(B) of this title, a decision of the Medicare Geographic Classification Review Board under section 1395ww(d)(10) of this title, or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, subject to clause (viii)(I), the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency’s 12-month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency’s census division, as applied to such agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

(II) the agency’s unduplicated census count of patients (entitled to benefits under this subchapter) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994 subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the Secretary’s best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.

(viii)(I) In the case of a provider with a 12-month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to “98 percent” were a reference to “100 percent”), the limit otherwise imposed under clause (v) for such provider and period shall be increased by $\frac{3}{4}$ of such difference.

(II) Subject to subclause (IV), for new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in clause (vii)(I) shall be equal to the median described in such clause (determined as if any reference in clause (v) to “98 percent” were a reference to “100 percent”).

(III) Subject to subclause (IV), in the case of a new provider for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

(IV) In the case of a new provider or a provider without a 12-month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this subchapter before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (ii) to reflect variations in wages among different areas.

(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning
during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.

(x) Notwithstanding any other provision of this subparagraph, in updating any limit under this subparagraph by a home health market basket index for cost reporting periods beginning during each of fiscal years 2000, 2001, 2002, and 2003, the update otherwise provided shall be reduced by 1.1 percentage points.

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act [42 U.S.C. 291 et seq., 300q et seq.] that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(1) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this subchapter.

(iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital at the time of the transfer.

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1395f(b) of this title shall not be allowable as reasonable costs.

(S) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(T) In determining the reasonable cost of ambulance services (as described in subsection § 1395x

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(93x594)uniform coding system specified by the Sec-
(93x603)the Secretary may provide that claims for such
(93x630)period ending with the midpoint of the fiscal year
(93x639)ment plus such charges exceed the cost actually
(93x648)payment with respect to such items or services
shall be reduced to the extent that such pay-
ment plus such charges exceeded the amount that
(93x657)(5)(A) Where physical therapy services, occu-
(93x665)wise due such provider in any fiscal period
shall be reduced to the extent that such pay-
ment plus such charges exceeded the cost actually
(93x675)amount that would have been paid if such serv-
ices (together with any additional costs that
(93x675)amount that would have been paid if such serv-
(93x692)movement relationship with such provider or other
organization (rather than under such arrange-
ment) plus the cost of such other expenses (in-
ccluding a reasonable allowance for traveltime
(93x684)ment plus such charges exceed the cost actually
shall be reduced to the extent that such pay-
ment plus such charges exceeded the amount that
(93x701)otherwise due such provider in any fiscal period
and determination of payment amounts for rou-
tments under certain percentage arrangements,
(93x837)See References in Text note below.
tine service costs of skilled nursing facilities, see subsections (a) through (c) of section 1395yy of this title.

(8) *Items unrelated to patient care.*—Reasonable costs do not include costs for the following—

(i) entertainment, including tickets to sporting and other entertainment events;
(ii) gifts or donations;
(iii) personal use of motor vehicles;
(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and
(v) education expenses for spouses or other dependents of providers of services, their employees or contractors.

(w) *Arrangements for certain services; payments pursuant to arrangements for utilization review activities.*

(1) The term “arrangements” is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this subchapter, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of subchapter XI of this chapter with respect to services furnished by a hospital or critical access hospital to patients insured under part A of this subchapter or entitled to have payment made for such services under part B of this subchapter or under a State plan approved under subchapter XIX of this chapter, by a quality control and peer review organization designated for the area in which such hospital or critical access hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital or critical access hospital and such organization under which such hospital or critical access hospital is obligated to pay to such organization, as a condition of receiving payment for hospital or critical access hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or critical access hospital to such patients.

(x) *State and United States.*

The terms “State” and “United States” have the meaning given to them by subsections (h) and (i), respectively, of section 410 of this title.

(y) *Extended care in religious nonmedical health care institutions.*

(1) The term “skilled nursing facility” also includes a religious nonmedical health care institution (as defined in subsection (ss)(1) of this section), but only (except for purposes of subsection (a)(2) of this section) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title.

(2) Notwithstanding any other provision of this subchapter, payment under part A of this subchapter may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A of this subchapter may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or
(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A of this subchapter for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eight of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1395e(a)(3) of this title).

(4) For purposes of subsection (i) of this section, the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

(2) *Institutional planning.*

An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the
year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1320a–1(g)(1) of this title in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1320a–1(h) of this title, or if no such agency is designated, to the appropriate health planning agency in the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1320a–1 of this title by reason of section 1320a–1(j) of this title);

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

(aa) Rural health clinic services and Federally qualified health center services

(1) The term ‘‘rural health clinic services’’ means—

(A) physicians’ services and such services and supplies as are covered under subsection (s)(2)(A) of this section if furnished as an incident to a physician’s professional service and items and services described in subsection (s)(10) of this section,

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1) of this section), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician’s service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term ‘‘rural health clinic’’ means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) of this section under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1385cc of this title, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic’s services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this subchapter;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg) of this section) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

So in original.
(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this subchapter, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 3-year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) 9 of 1302(7) [42 U.S.C. 300e–1(7)] of the Public Health Service Act, (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act [42 U.S.C. 254e(a)(1)(A)] because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) 9 of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 322(a)(1)(B) of that Act [42 U.S.C. 254e(a)(1)(B)], (i) has filed an agreement with a Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this subchapter, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1395l of this title, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this subchapter or subchapter XIX of this chapter and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this subchapter and subchapter XIX of this chapter, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term “Federally qualified health center services” means—
(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and
(B) preventive primary health services that a center is required to provide under sections 329, 330, and 340 of the Public Health Service Act.

when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term “Federally qualified health center” means an entity which—
(A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act [22 U.S.C. 254b], or
(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act [22 U.S.C. 254b];
(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
(C) was treated by the Secretary, for purposes of part B of this subchapter, as a comprehensive Federally funded health center as of January 1, 1990; or
(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act [25 U.S.C. 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(5)(A) The term “physician assistant” and the term “nurse practitioner” mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law); and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term “clinical nurse specialist” means, for purposes of this subchapter, an individual who—
(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and
(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term “collaboration” means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or

*See References in Text note below.
that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

(bb) Services of a certified registered nurse anesthetist

(1) The term “services of a certified registered nurse anesthetist” means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term “certified registered nurse anesthetist” means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

(cc) Comprehensive outpatient rehabilitation facility services

(1) The term “comprehensive outpatient rehabilitation facility services” means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations prescribed by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician:

(A) physicians’ services;
(B) physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy;
(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;
(D) social and psychological services;
(E) nursing care provided by or under the supervision of a registered professional nurse;
(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;
(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities, excluding, however, any item or service if it would not be included under subsection (b) of this section if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this subchapter.

(2) The term “comprehensive outpatient rehabilitation facility” means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians’ services (rendered by physicians, as defined in subsection (r)(1) of this section, who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) of this section to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (a) of this section;

(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.
(dd) Hospice care; hospice program; definitions; certification; waiver by Secretary

(1) The term “hospice care” means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individuals) established and periodically reviewed by the individual’s attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,

(C) medical social services under the direction of a physician,

(D) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians’ services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this subchapter.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term “hospice program” means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals,

(ii) provides for such care and services in individuals’ homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1395dd(d) of this title with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1) of this section),

(II) one registered professional nurse, and

(III) one social worker,

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor;

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be “terminally ill” if the individual has a medical prognosis that the individual’s life expectancy is 6 months or less.

(B) The term “attending physician” means, with respect to an individual, the physician (as defined in subsection (r)(1) of this section), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the
individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this subchapter so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1395cc of this title and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this subchapter.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(i)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) or (C), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) or (C) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

(ee) Discharge planning process

(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this subchapter and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient’s representative, or patient’s physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient’s likely need for appropriate post-hospital services, including hospice services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available.

(E) The discharge planning evaluation process must be included in the patient’s medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient’s representative).

(F) Upon the request of a patient’s physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph shall be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1395a of this title, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1395cc(a)(1)(S) of this title) or which has such an interest in the hospital.

(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or

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10So in original. Probably should be “paragraph (2)(H)(i)”.

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§ 1395x

**Partial hospitalization services**

(1) The term “partial hospitalization services” means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician’s diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The terms and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual’s condition),

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual’s care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or treatment of the individual’s condition, reasonably expected to improve or maintain the individual’s condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care.

(B) For purposes of subparagraph (A), the term “community mental health center” means an entity—

(i) providing the services described in section 1915(c)(4) of the Public Health Service Act [42 U.S.C. 300x–4(c)(4)]; and

(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located.

**(gg) Certified nurse-midwife services**

(1) The term “certified nurse-midwife services” means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife’s service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician’s service.

(2) The term “certified nurse-midwife” means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

**(hh) Clinical social worker; clinical social worker services**

(1) The term “clinical social worker” means an individual who—

(A) possesses a master’s or doctor’s degree in social work;

(B) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)(i) is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii) in the case of an individual in a State which does not provide for licensure or certification—

(I) has completed at least 2 years or 3,000 hours of post-master’s degree supervised clinical social work practice under the supervision of a master’s level social worker in an appropriate setting (as determined by the Secretary), and

(II) meets such other criteria as the Secretary establishes.

(2) The term “clinical social worker services” means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an individual in a State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.

**(ii) Qualified psychologist services**

The term “qualified psychologist services” means such services and supplies furnished as an incident to the services furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician’s service.
The term “screening mammography” means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician’s interpretation of the results of the procedure.

The term “covered osteoporosis drug” means an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—

(1) the individual’s attending physician certifies that the individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual’s home (except when receiving items and services referred to in subsection (m)(7) of this section).

The term “speech-language pathology services; audiology services” means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

(2) The term “audiology services” means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

(3) In this subsection:

(A) The term “qualified speech-language pathologist” means an individual with a master’s or doctoral degree in speech-language pathology who—

(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master’s or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

(B) The term “qualified audiologist” means an individual with a master’s or doctoral degree in audiology who—

(i) is licensed as an audiologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master’s or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

The term “critical access hospital; critical access hospital services” means a facility certified by the Secretary as a critical access hospital under section 1395i–4(e) of this title.

The term “screening pap smear; screening pelvic exam” means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician’s interpretation of the results of the test, if the individual involved has not had such a test during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3).

(2) The term “screening pelvic exam” means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

(3) A woman described in this paragraph is a woman who—

(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).

The term “prostate cancer screening tests” means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2002, such other procedures as the Secretary finds appro-
 priate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

(pp) Colorectal cancer screening tests
(1) The term “colorectal cancer screening test” means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:
   (A) Screening fecal-occult blood test.
   (B) Screening flexible sigmoidoscopy.
   (C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.
   (D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.
(2) In paragraph (1)(C), an “individual at high risk for colorectal cancer” is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn’s Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

(qq) Diabetes outpatient self-management training services
(1) The term “diabetes outpatient self-management training services” means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as defined in paragraph (2)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual’s diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual’s diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual’s condition.
(2) In paragraph (1)—
   (A) a “certified provider” is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this subchapter; and
   (B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this subchapter) with diabetes as meeting standards for furnishing the services.

(rr) Bone mass measurement
(1) The term “bone mass measurement” means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician’s interpretation of the results of the procedure.
(2) For purposes of this subsection, the term “qualified individual” means an individual who is (in accordance with regulations prescribed by the Secretary)—
   (A) an estrogen-deficient woman at clinical risk for osteoporosis;
   (B) an individual with vertebral abnormalities;
   (C) an individual receiving long-term glucocorticoid steroid therapy;
   (D) an individual with primary hyperparathyroidism; or
   (E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this subchapter.

(ss) Religious nonmedical health care institution
(1) The term “religious nonmedical health care institution” means an institution that—
   (A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;
   (B) is lawfully operated under all applicable Federal, State, and local laws and regulations;
   (C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;
   (D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;
   (E) provides such nonmedical items and services to inpatients on a 24-hour basis;
   (F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;
   (G)(i) is not owned by, under common ownership with, or has an ownership interest in, a provider of medical treatment or services; or
      (ii) is not affiliated with—
   (I) a provider of medical treatment or services; or
(II) an individual who has an ownership interest in a provider of medical treatment or services;

(H) has in effect a utilization review plan which—

(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

(I) provides the Secretary with such information as the Secretary may require to implement section 1395i–5 of this title, including information relating to quality of care and coverage determinations; and

(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

(3)(A)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1395i–5(a)(2) of this title the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A of this subchapter for services provided in such an institution.

(B)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not subject a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A of this subchapter, are excessive, or are fraudulent.

(B) For purposes of paragraph (1)(G)(i), none of the following shall be considered to create an affiliation:

(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.

(tt) Post-institutional home health services; home health spell of illness

(1) The term “post-institutional home health services” means home health services furnished to an individual—

(A) after discharge from a hospital or rural primary care11 hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term “home health spell of illness” with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) on which such individual is furnished post-institutional home health services, and

(ii) which occurs in a month for which the individual is entitled to benefits under part A of this subchapter, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care11 hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1) of this section nor provided home health services.

(Aug. 14, 1935, ch. 531, title XVIII, § 1861, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 383; amended Pub. L. 89–713, § 7, Nov. 2, 1966, 80 Stat. 1111; Pub. L. 90–248, title I, §§ 127(a), 129(a), (b), (c)(9)(C), (10), (11), 132(a), 133(a), (b), 134(a), 143(a), 144(a)–(d), Jan. 2, 1968, 81 Stat. 846–850, 852, 857, 858; Pub. L. 91–690, Jan. 12, 1971, 81 Stat. 2067; Pub. L. 92–663, title II, §§211(b), (c)(1), 221(c)(4), 223(a)–(d), 237(a), (c), (d)(1), (f), 234(a)–(f), 237(c), 244(c), 246(b), 248, 249(b), 251(a)(1), (b)(1), (c), 252(a), 256(b), 264(a), 265, 267, 273(a), 278(a), 278(a) (4)–(15), (b)(6), (10), (11), (13), (14), 279(a), (c), 286(a), (12).
The Indian Self-Determination Act, referred to in subsec. (aa)(4)(D), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, as amended, which is classified principally to part A (§450 et seq.) of chapter 18 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.


AMENDMENTS
1999—Subsec. (o)(7). Pub. L. 106–113, §100(a)(a)(6) [title III, §309(a)], amended par. (7) generally. Prior to amendment, par. (7) read as follows: “provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and”. Subsec. (p)(1). Pub. L. 106–113, §100(a)(a)(6) [title II, §221(b)(1)(A)], substituted “(3), (4), or (5)” for “(3)”. Subsec. (r)(1). Pub. L. 106–113, §100(a)(a)(6) [title II, §221(b)(1)(B)], inserted “for purposes of subsection (p)(1) of this section and” after “but only”.


Subsec. (v). Pub. L. 105–277, §2751(a), inserted “subject to clause (xxiv)(x)”, before “the Secretary” in introductory provisions.


Subsec. (c). Pub. L. 105–33, §454(a)(1)(A), in fifth sentence after par. (9), substituted “includes a religious nonmedical health care institution (as defined in subsection (aa)(1) of this section),” for “includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts,” and inserted “consistent with section 1396–5 of this title” before the period. Pub. L. 105–33, §4201(c)(1), substituted “critical access” for “rural primary care” in last sentence.

Subsec. (h). Pub. L. 105–33, §4512(b)(5)(D)(i), inserted “or” and by other arrangements with them made by the facility” after “skilled nursing facilities”.

Subsec. (m). Pub. L. 105–33, §4612(a), inserted at end of closing provisions “For purposes of paragraphs (1) and (4), the term ‘part-time or intermittent services’ means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours daily and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395k(a)(2)(C) and 1395n(a)(2)(A) of this title, ‘intermittent’ means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions (with extensions for exceptional circumstances when the need for additional care is finite and predictable)).”

Subsec. (n). Pub. L. 105–33, §4106(b)(1), inserted before semicolon in first sentence “and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual’s use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)”.

Subsec. (o). Pub. L. 105–33, §4312(b)(1)(D), inserted at end of closing provisions “The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.”

Subsec. (p)(7). (8). Pub. L. 105–33, §4312(b)(1)(A)–(C), added par. (7) and redesignated former par. (7) as (8).

Subsec. (q). Pub. L. 105–33, §4312(e)(2), inserted at end of closing provisions “The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.”

Subsec. (r)(4)(A)(v). Pub. L. 105–33, §4312(e)(1), inserted “and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,” after “as the Secretary may find necessary.”

Subsec. (r)(5). Pub. L. 105–33, §4151(a), struck out “demonstrated by x-ray to exist” following “to correct a subluxation.”

Subsec. (s)(2)(K)(i). Pub. L. 105–33, §4511(a)(2)(A)(i), 4512(a), struck out “(I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1396r(a) of this title), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1395w(d)(2)(B) of this title) that is designated, under section 332A(a)(1)(A) of the Public Health Service Act, as a health professional shortage area,” after “physician (as so defined)” and inserted at end “and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service, and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,”.

Subsec. (s)(2)(K)(ii). Pub. L. 105–33, §4151(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: “services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner (as defined in subsection (aa)(6) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) in a skilled
nursing facility or nursing facility (as defined in section 1563(a)(2) of this title) which the nurse practitioner is legally authorized to perform by the State in which the services are performed, or


Subsec. (g)(12)(C). Pub. L. 105–33, § 4106(a)(1A), struck out "and" at end.

Subsec. (g)(14). Pub. L. 105–33, § 4102(c), inserted "and screening pelvic exam" after "screening pap smear".

Subsec. (g)(15) to (17). Pub. L. 105–33, § 4106(a)(1)(B)–(D), added par. (15) and redesignated former paras. (15) and (16) as (16) and (17), respectively.

Subsec. (h). Pub. L. 105–33, § 4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (v)(1)(H)(i). Pub. L. 105–33, § 4102(b)(2)(A), substituted "the surety bond requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section" for "the financial security requirement described in subsection (o)(7) of this section".

Subsec. (v)(1)(H)(ii). Pub. L. 105–33, § 4102(b)(2)(B), substituted "the surety bond requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section" for "the financial security requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section".

Subsec. (v)(1)(H)(ii). Pub. L. 105–33, § 4102(b)(2)(B), struck out closing provisions which read as follows: "of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies bracket at end and realigned margins.

Subsec. (v)(1)(L)(i)(II). Pub. L. 105–33, § 4602(a)(1), (2), inserted "of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies" before comma at end and realigned margins.


Subsec. (v)(1)(L)(ii). Pub. L. 105–33, § 4604(b), substituted "services furnished" for "hospital or skilled nursing facility".

Subsec. (v)(1)(L)(ii). Pub. L. 105–33, § 4604(b), substituted "or on or after July 1, 1997, and before October 1, 1997" after "July 1, 1996".


Subsec. (v)(1)(O)(i). Pub. L. 105–33, § 4404(a)(1), struck out "and (if applicable) a return on equity capital" after "capital indebtedness" and substituted "provider of services", "hospital or skilled nursing facility", "capital indebtedness", "the historical cost of the asset", "including under this subchapter", "the lower of cost or market", and "the unit cost of the asset", respectively, for "clause (iii) for "clause (iv)", and "the historical cost of the asset", "as recognized under this subchapter, less depreciation provided, to the owner of record as of August 5, 1997, or, in the case of an asset not in existence as of such date, the owner of record of the asset after such date", or the acquisition cost of such asset to the new owner.

Subsec. (v)(1)(O)(i) to (iv). Pub. L. 105–33, §§ 4404(a)(2), (3), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: "Such regulations shall provide for recapture of the probable intent of Congress.


Subsec. (y)(1). Pub. L. 105–33, § 4454(a)(1)(B)(iii), which directed the amendment of this subsec. by inserting "consistent with section 1305v-5 of this title" before the period, was executed by making the insertion in par. (1) to reflect the probable intent of Congress.

Subsec. (y)(2). Pub. L. 105–33, § 4454(a)(1)(B)(iii), substituted " extends critical access in religious nonmedical health care institutions for "Post-hospital extended care in Christian Science skilled nursing facilities" in heading. Subsec. (y)(1). Pub. L. 105–33, § 4454(a)(1)(B)(iii), which directed the amendment of this subsec. by inserting "consistent with section 1305v-5 of this title" before the period, was executed by making the insertion in par. (1) to reflect the probable intent of Congress.

Subsec. (y)(3). Pub. L. 105–33, § 4454(a)(1)(B)(iv), substituted "the financial security requirement described in subsection (o)(7) of this section" for "the financial security requirement described in subsection (o)(7) of this section and the financial security requirement described in subsection (o)(8) of this section".


Section 1395x

Subtitle B

Subtitle C

Subtitle D

Subtitle E

Subtitle F

Subtitle G

Subtitle H

Subtitle I

Subtitle J

Subtitle K

Subtitle L

Subtitle M

Subtitle N

Subtitle O

Subtitle P

Subtitle Q

Subtitle R

Subtitle S

Subtitle T

Subtitle U

Subtitle V

Subtitle W

Subtitle X

Subtitle Y

Subtitle Z

For purposes of this subchapter, a physician assistant, nurse practitioner, or clinical nurse specialist who performs... and added subpar. (B).

Subsec. (a)(7)(B). Pub. L. 105–33, § 4205(c)(1), inserted “before period at end ‘‘ or, if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of qualified health clinic”.


Subsec. (dd)(2)(A)(i)(I). Pub. L. 105–33, § 4445(a), substituted “subparagraphs (A), (C), and (H)” for “subparagraphs (A), (C), (F), and (H)”.

Subsec. (dd)(2)(B)(i). Pub. L. 105–33, § 4445(b), in concluding provisions, inserted “or, in the case of a physician described in subclause (I), under contract with” after “employed by”.


Subsec. (ee)(2)(D). Pub. L. 105–33, § 4322(a)(1), inserted before period at end “, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available”.


Subsec. (mm). Pub. L. 105–33, § 4321(c)(2), amended heading and text of subsec. (mm) generally. Prior to amendment, text read as follows: “(1) The term ‘rural primary care hospital’ means a facility designated by the Secretary as a rural primary care hospital under section 330c–1(a)(2) of this title.

“(2) The term ‘inpatient rural primary care hospital services’ means medical and other health services furnished by a rural primary care hospital.”


Subsec. (aa)(4)(A)(ii)(I). Pub. L. 104–299 which directed amendment of subcl. (I) by substituting “section 330 (other than subsection (h))” for “section 329, 330, or 340”, was executed to subcl. (II) to reflect the probable intent of Congress.


Subsec. (a)(2). Pub. L. 103–432, § 102(g)(4)(B), substituted “hospital or rural primary care hospital” for “hospital”.


Pub. L. 103–432, § 147(e)(4), substituted “clauses (i) or (ii) of subsection (a)(2)(K) of this section” for “subsection (a)(2)(K) of this section”.

Subsec. (e)(4). Pub. L. 103–432, § 104, substituted “physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii) of this section) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law” for “physician”.

Subsec. (h)(3). Pub. L. 103–432, § 146(b)(1), substituted “or occupational therapy or speech-language pathology services” for “or, occupational, or speech therapy”.

Subsec. (m)(2). Pub. L. 103–432, § 146(b)(2), substituted “or occupational therapy or speech-language pathology services” for “or, occupational, or speech therapy”.

Subsec. (m)(5). Pub. L. 103–432, § 146(b)(3), substituted “and a covered osteoporosis drug (as defined in subsection (kk) of this section), but excluding other drugs” for “but excluding drugs”.

Subsec. (p). Pub. L. 103–432, § 146(b)(3), substituted “speech-language pathology services” for “speech pathology services” after “term ‘outpatient physical therapy services’ also includes” in third sentence of closing provisions.


Subsec. (s)(2)(O). (P). Pub. L. 103–432, § 147(f)(6)(B)(III)(II), redesignated subpar. (P) as (O) and struck out former subpar. (P) which read as follows: “a covered osteoporosis drug and its administration (as defined in subsection (jj) of this section) furnished on or after January 1, 1991, and on or before December 31, 1995, and”.

Subsec. (s)(3). Pub. L. 103–432, § 145(b), inserted “and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act” after “necessary”.

Subsec. (v)(1)(L)(III). Pub. L. 103–432, § 158(a)(1), substituted “determined using the survey of the most recent available wages and wage-related costs of hospitals” for “as of such date to hospitals”.

Subsec. (aa)(2). Pub. L. 103–432, § 147(f)(4)(A), in last sentence of closing provisions, substituted “approval as such a clinic” for “certification as such a clinic” and “Secretary’s approval or disapproval” for “(the Secretary’s approval or disapproval) of the certification”. (j) defining “covered osteoporosis drug”, as.


Pub. L. 103–432, § 147(f)(6)(A), (B)(i), amended subsec. (j), defining “covered osteoporosis drug”, in introductory provisions, by striking out “a bone fracture relat-
ed to” before “post-menopausal osteoporosis” and substituting “individual by a home health agency if” for “individual if”, and in (par. (1), by substituting “individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual for “patient”.


1995—Subsec. (s)(2)(J). Pub. L. 103–66, § 13565, substituted “the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of for “the costs of such facilities in second sentence.


Subsec. (s)(2)(L)(ii). Pub. L. 101–508, § 4156(a)(1), inserted “, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens” after “such devices”.


Subsec. (s)(2)(M). Pub. L. 101–508, § 4156(a)(1), redesignated former subcl. (II) as (III). Former subcl. (II) read as follows: “In establishing limits under this subparagraph, the Secretary shall—

(i) utilize a wage index that is based on verified wage data obtained from home health agencies, and—

(ii) base such limits on the most recent verified wage data available, which data may be for cost reporting periods beginning no earlier than July 1, 1985. In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this subchapter until such date as the Secretary determines that such data has been satisfactorily provided.”


Subsec. (hh). Pub. L. 101–1001, § 1395x, substituted “screening mammography” for “outpatients”, and substituted “outpatients or by a community mental health center (as defined in subparagraph (B)),” for “outpatients”, and added subpar. (B).

Subsec. (ii). Pub. L. 101–1001, § 1395x, redesignated former subpar. (ii) as (iii), and substituted “to such services in cl. (ii)” for “for ”.

Subsec. (jj). Pub. L. 101–1001, § 1395x, redesignated par. (14) as (15) and redesignated former par. (14) as (16).

Subsec. (kk)(1). Pub. L. 101–1001, § 1395x, added subpar. (1), and designated existing provisions as subpars. (2) and (3).

Subsec. (ll)(1). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (mm). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (nn). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (oo). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (pp). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (qq). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (rr). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (ss). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

Subsec. (tt). Pub. L. 101–1001, § 1395x, added subpar. (1) and redesignated former par. (1) as (2).

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. (aa)(1)(B). Pub. L. 101–239, §6213(b), substituted “as defined in paragraph (3),” for “(as defined in paragraph (3), or)” after “Secretary),”.

Subsec. (aa)(2). Pub. L. 101–239, §6213(c), in second sentence substituted “designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or a population group which the Secretary determines has a health manpower shortage under section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 329(a)(5)(B) of that Act,” for “medical care manpower,”.

Subsec. (aa)(3). Pub. L. 101–239, §6213(a), added subpar. (J) and redesignated former subpar. (J) as (K).


Subsec. (bb). Pub. L. 101–239, §6113(b)(2)(B), inserted “social worker services” after “social worker” in heading, redesignated existing provisions as pars. (1), redesignated former pars. (1) to (3) as subpars. (A) to (C), respectively, in subpar. (C), redesignated former subpars. (A) and (B) as cl. (1) and (ii), respectively, in cl. (ii), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added par. (2).

Subsec. (cc). Pub. L. 101–239, §6113(a), struck out “on-site at a community mental health center (as such term is used in the Public Health Service Act),” and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,” after “as defined by the Secretary”.

Subsecs. (dd) to (ff). Pub. L. 101–234, §201(a), amended Pub. L. 100–360, §§203(b), 204(a)(2), 205(b), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.


Subsec. (hh). Pub. L. 101–239, §§6113(b)(2)(B), inserted “social worker services” after “social worker” in heading, redesignated existing provisions as pars. (1), redesignated former pars. (1) to (3) as subpars. (A) and (B) as cls. (1) and (ii), respectively, in cl. (ii), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added par. (2).

Subsec. (ii). Pub. L. 101–239, §6113(a), struck out “on-site at a community mental health center (as such term is used in the Public Health Service Act),” and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,” after “as defined by the Secretary”.

Subsecs. (jj) to (ll). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§203(b), 204(a)(2), 205(b), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.


Subsec. (bb). Pub. L. 100–360, §104(d)(4)(A), struck out “needed by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,” after “as defined by the Secretary”.

Subsec. (cc). Pub. L. 100–360, §104(d)(4)(A), struck out subsec. (aa) which defined “spell of illness”.


Subsec. (m)(5). Pub. L. 98–369, §2321(e)(1), directed the substitution of "and durable medical equipment" for "and the use of medical appliances" was executed by making the substitution for "and the use of medical appliances" as the probable intent of Congress.


Subsec. (p)(1). Pub. L. 98–369, §2341(a), substituted "paragraph (1) or (3) of subsection (r) of this section" for "subsection (r)(2) of this section".

Subsec. (p)(2). Pub. L. 98–369, §2342(a), substituted "by a physician as so defined" or by a qualified physical therapist and is periodically reviewed by a physician (as so defined)" for","and is periodically reviewed, by a physician (as so defined)".

Subsec. (r)(3). Pub. L. 98–617, §3(b)(7), substituted "under subsections (k), (m), and (p) of this section and sections 1395(a), 1395a(2)(F)(i), and 1395n of this title" for "under subsections (k) and (m) and sections 1395(a) and 1395n of this title" before "is consistent with the policy".

Subsec. (s)(2)(C). Pub. L. 98–369, §2324(a), substituted ''as defined in clause (ii)'' for ''provided in an emergency room'', and added cl. (ii).

Subsec. (s)(2)(H). Pub. L. 98–369, §2322(a), designated existing provisions as cl. (i), substituted therefor "as defined in clause (ii)" and added cl. (ii).

Subsec. (s)(10). Pub. L. 98–369, §2323(a), designated existing provisions as cl. (i), substituted therefor "as defined in clause (ii)" and added cl. (ii).


Subsec. (v)(1)(A). Pub. L. 98–369, §2323(a), substituted "as so defined" for "", and is periodically reviewed, by a physician (as so defined)".

Subsec. (v)(1)(J). Pub. L. 97–248, §103(a), substituted "any skilled nursing facility that either was a distinct part of or directly operated by a hospital or was in a close, formal satellite relationship with a participating hospital, and in the case of the latter, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection would not exceed 150 percent of the costs determined by the application of this subparagraph, redesignated the remainder as cl. (ii), and added cl. (i).


Subsec. (v)(1)(H)(ii). Pub. L. 97–248, §109(b)(1), struck out "(i)" and "(ii) which determines the amount payable by the home health agency on the basis of the percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency".


Subsec. (v)(1)(E). Pub. L. 97–248, §102(a), struck out provisions that this subparagraph would not apply to any skilled nursing facility that either was a distinct part of or directly operated by a hospital or was in a close, formal satellite relationship with a participating hospital, in the case of the latter, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection would not exceed 150 percent of the costs determined by the application of this subparagraph, redesignated the remainder as cl. (ii), and added cl. (i).


Subsec. (v)(1)(H)(ii). Pub. L. 97–248, §109(b)(1), struck out "(i)" and "(ii) which determines the amount payable by the home health agency on the basis of the percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency".


Subsec. (v)(1)(J). Pub. L. 97–248, §103(a), substituted provisions that cost regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities for provisions that such regulations would provide that an inpatient routine nursing salary cost differential would be allowable as a reimbursable cost of hospitals, at a rate not to exceed 5 percent, to be applied under the same methodology used for the nursing salary cost differential for the month of April 1981.

Subsec. (v)(1)(L). Pub. L. 97–248, §101(a)(2), struck out cl. (i) which provided that the Secretary, in determining the amount of the payment "for the provision of general inpatient hospital
services, could not recognize as reasonable, routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceeded 100 percent of the mean of such routine operating costs per diem for hospitals, or, in the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary could determine and struck out "(ii)".

Pub. L. 97–248, §105(a), inserted "free standing" after "costs per visit for".


Subsec. (v)(7). Pub. L. 97–248, §101(d), redesignated existing provisions as subpar. (A) and added subpar. (B).


Subsec. (w)(1). Pub. L. 97–248, §122(d)(2), substituted "home health agency, or hospice program" for "or home health agency"


Subsec. (v)(1)(G)(1). Pub. L. 97–35, §2102(a)(1), substituted "there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital for the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more" in provision following subcl. (III).

Pub. L. 97–35, §2114, substituted "the Secretary or such agent as the Secretary may designate" for "an organization or agency with review responsibility as is otherwise provided for under part A of subchapter XI of this chapter" in provision preceding subcl. (I).

Subsec. (v)(1)(G)(v). Pub. L. 97–35, §2102(a)(2), substituted provisions that the determination under cl. (i) of this subparagraph, in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, be made on the basis of only the public hospitals which are in the area of the hospital and which are under common ownership with that hospital for provisions that public hospitals under common ownership may elect to be treated as a single hospital, and beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment was made to the hospital only because of this subparagraph or section 1396a(h) of this title for such determination.


Pub. L. 97–35, §2144(a), designated existing provisions as cl. (I) and added cl. (II).

Subsec. (w)(2). Pub. L. 97–35, §2193(c)(9), substituted "subchapter XIX of this chapter" for "subchapter V or XIX of this chapter".

Subsec. (bb). Pub. L. 97–35, §2121(d), struck out subsec. (bb) which defined "alcohol detoxification facility" as the probable intent of Congress, in view of the substitution of "skilled nursing facility" for "detoxification facility," as the National Fire Protection Association (23rd edition, 1973) and redesignated former cl. (C) as (B).

Subsec. (cc)(1). Pub. L. 97–248, §951(a), inserted "(of which at least two must be physicians described in section (r)(1) of this section)" after "two or more physicians".

Subsec. (m)(4). Pub. L. 97–248, §930(l), inserted "who has successfully completed a training program approved by the Secretary" after "health aide"

Subsec. (n). Pub. L. 97–248, §930(m), struck out subsec. (n) which defined "post-hospital home health services".

Subsec. (o). Pub. L. 97–248, §930(n)(2), in provisions following par. (7), struck out provision that "home health agency" was not to include a private organization which was not a nonprofit organization exempt from Federal income taxation under section 501 of title 26 unless it was licensed pursuant to State law and met such additional standards and requirements as prescribed by regulations.


Subsec. (o)(2). Pub. L. 97–248, §930(a), amended cl. (2) generally to expand definition of "physician" to include doctors of dental surgery or dental medicine acting within the scope of their licenses.


Subsec. (v)(4). Pub. L. 97–249, §937(a), substituted "services related to the condition of aphakia" for "establishing the necessity for prosthetic lenses".


Subsec. (s)(10) to (14). Pub. L. 96–611, §1(a)(1), added par. (10) and redesignated former pars. (10) to (13) as (11) to (14), respectively.

Subsec. (u). Pub. L. 96–499, §933(c), inserted "comprehensive outpatient rehabilitation facility," after "nursing facility"

Pub. L. 96–499, §931(c), inserted "detoxification facility;".


Subsec. (2). Pub. L. 96–499, §933(d), which purported to substitute "skilled nursing facility, comprehensive outpatient rehabilitation facility," for "extended care facility," was executed by inserting "comprehensive outpatient rehabilitation facility," after "skilled nursing facility," as the probable intent of Congress, in view of the substitution of "skilled nursing facility"
for “extended care facility” by section 278(b)(6) of Pub. L. 92–603.

Subsec. (aa)(1)(A). Pub. L. 96–611, §1(b)(3), inserted reference to items and services described in subsection (s)(10) of this section.


1977—Subj. (jj)(11). Pub. L. 95–142, §3(a)(2), substituted provisions relating to compliance with requirements of section 1320a–3 of this title, for provisions relating to disclosure of ownership, corporate status, etc., information to the Secretary or his delegate.

Subsec. (jj)(13). Pub. L. 95–142, §21(a), struck out “and” after “nursing facilities”.


Subsec. (s). Pub. L. 95–210, §1(g), (h), added par. (2) of (par) 2) and in provisions following par. (9) inserted “a”, “a rural health clinic,” after “independent of a physician’s office”.

Subsec. (s)(6). Pub. L. 95–216 inserted “which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of an automobile is determined to be necessary on the basis of the individual’s medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe” after “wheelchairs”.


Subsec. (w)(2). Pub. L. 95–142, §5(m), inserted “part B of this subchapter or under” after “or entitled” and inserted provisions for the purpose of redefining “skilled nursing facility” for “extended care facilities”, and “a” for “an”.


Subsec. (w). Pub. L. 94–182, §112(a)(i), designated existing provisions as par. (1) and added par. (2).

1971—Subsec. (a)(2). Pub. L. 92–603, §278(a)(4), substituted “skilled nursing facility” for “extended care facility” and “a” for “an”.

Subsec. (b)(5). Pub. L. 92–603–278(a)(5), substituted existing second sentence of subsec. (b) as par. (6) and in subsec. (b)(6) as so designated inserted reference to services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association.


Subsec. (p). Pub. L. 92–603, §251(a)(1), (b)(1), 278(a), inserted provisions covering physical therapy services of a licensed physical therapist other than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, inserted “in addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility”.

Subsec. (q). Pub. L. 92–603, §227(f), substituted “section (b)(6) of this section” for “the last sentence of subsection (b) of this section” in parenthetical phrase.

Subsec. (r). Pub. L. 92–603, §§211(c)(2), 256(b), 278(a), 273(a), inserted “or (C) the certification required by section 1385a(a)(2)(E) of this title”, inserted provision so as to include doctors in one of the specified arts legally authorized to practice such art in the country in which inpatient hospital services referred to in section 1385a(a)(4) are furnished, added cl. (4) covering doctors of optometry who are legally authorized to practice optometry by the State in which they perform such functions, but only with respect to establishing the necessity for prosthetic lenses, and added cl. (5) providing for the inclusion of chiropractor services.

Subsec. (s). Pub. L. 92–603, §252(a), inserted (including colostomy bags and supplies directly related to colostomy care) after “organ”.

Subsec. (u). Pub. L. 92–603, §227(d)(1), 278(a)(12), substituted “skilled nursing facility, or home health agency, or, for purposes of sections 1395(g) and 1395(e) of
this title, a fund." for "extended care facility, or home health agency.").

Subsec. (v)(1). Pub. L. 92–603, §§ 223(a), (b), (c), (d), 226(b)(1), (2), (3), (4), 226(b), 276(c)(11), inserted definition of the costs of services, inserted provision that the regulation for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonably based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, inserted parenthetical provisions covering exclusion of costs, substituted "the necessary costs of efficiently delivering covered services covered by the insurance programs" for "the costs with respect to individuals covered by the insurance programs", designated existing provisions as subpars. (A) and (B), and added subpars. (C), (D), and (E), and substituted "skilled nursing facilities" and "a" for "an".

Subsec. (v)(2). Pub. L. 92–603, §§ 278(a)(13), substituted "skilled nursing facility" for "extended care facility".


Subsec. (v)(6). Pub. L. 92–603, §§ 223(i), 251(c), redesignated former par. (4) as (6).


Subsecs. (w), (y). Pub. L. 92–603, §§ 278(a)(14), (15), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

Subsec. (z). Pub. L. 92–603, §§ 237(b)(3), 278(b)(6), added subsec. (z) and substituted "skilled nursing facility" for "extended care facility".

1971—Subsec. (e)(5). Pub. L. 91–690 authorized the Secretary, until January 1, 1976, to waive the requirement relating to the provision of 24 hour nursing services rendered or supervised by a registered professional nurse.

1968—Subsec. (e). Pub. L. 90–248, § 129(c)(5), inserted reference to section 1395n(b) in first and third sentences and inserted "or diagnostic services" after "hospital services" in third sentence.

Pub. L. 90–248, § 139(a), in second sentence after par. (8), changed definition of hospitals for purposes of making payments for emergency hospital services by deleting provision that hospital meet requirements of par. (1) to (4), by requiring that such hospitals have full-time nursing services, be licensed as a hospital, and be primarily engaged in providing not nursing care and related services but medical or rehabilitative care by or under the supervision of a doctor of medicine or osteopathy.

Subsec. (p). Pub. L. 90–248, §§ 129(c)(10), 133(b), struck out definition of "outpatient hospital diagnostic services" and inserted definition of "outpatient physical therapy services", respectively.


Subsec. (s). Pub. L. 90–248, §§ 144(a)–(c), struck out "unless they would otherwise constitute inpatient health services, extended care services, or home health services", in text preceding par. (1), inserted after "hospital" in sentence following par. (9) "which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395(d) of this title", and inserted sentence following par. (13) providing that medical and other health services (other than physicians' services and services incident to physicians' services) furnished a patient of a facility which meets the definition of a hospital for emergency services will be covered under the medical insurance program only if such facility satisfies such health and safety requirements as are appropriate for the item or service furnished as the Secretary may determine are necessary.

Subsec. (s)(2)(A) to (C). Pub. L. 90–248, § 129(a), designated existing provisions as subpars. (A) and (B) and added subpar. (D).

after July 1, 1996, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Section 4106(d) of Pub. L. 105–33 provided that: “The amendments made by this section (amending this section and sections 1395w–4, 1395aa, 1396a, and 1396n of this title) shall apply to bone mass measurements performed on or after July 1, 1996.

Amendment by section 4201(c)(1), (2) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Section 4206(b)(2) of Pub. L. 105–33 provided that: “The amendment made by paragraph (1) [amending this section] applies to waiver requests made on or after January 1, 1998.”

Section 4205(c)(2) of Pub. L. 105–33 provided that: “The amendment made by subsection (a) [amending this section] applies to services furnished on or after October 1, 1997.”

Amendment by section 4432(b)(5)(D), (E) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Section 4322(d)(1) of Pub. L. 105–33 provided that: “The amendments made by subsection (a) [amending this section] apply to changes of ownership that occur after the third month beginning after the date of enactment of this section [Aug. 5, 1997].”

Amendment by section 4322(b)(5)(D), (E) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1996, see section 4322(d) of Pub. L. 105–33, set out as a note under section 1395l–3 of this title.

Section 444(b) of Pub. L. 105–33 provided that: “The amendments made by subsection (a) [amending this section] apply to changes of ownership that occur after the date of enactment of this section [Aug. 5, 1997].”

Amendment by section 445 and 446 of Pub. L. 105–33 applicable to benefits furnished on or after Aug. 5, 1997, except as otherwise provided, see section 449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

Amendment by section 454(a)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that the Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395k–5 of this title.

Amendment by section 4511(a)(1)–(2)(B), (d) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4512(a) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4512(b) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Section 4513(b) of Pub. L. 105–33 provided that: “The amendment made by subsection (a) [amending this section] applies to services furnished on or after January 1, 2000.”

Section 4557(b) of Pub. L. 105–33 provided that: “The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 1998.”

Section 4600(c) of Pub. L. 105–33 provided that: “The amendments made by this section [amending this section and section 1395cc of this title] apply to cost reporting periods beginning on or after October 1, 1997.”

Amendment by section 4611(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Section 4612(b) of Pub. L. 105–33 provided that: “The amendment made by subsection (a) [amending this section] applies to services furnished on or after October 1, 1997.”

Section 107(b) of Pub. L. 103–432 provided that: “The amendment made by subsection (b) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act [Oct. 31, 1994].”

Amendment by section 145(b) of Pub. L. 103–432 applicable to mammography furnished by the facility on and after the first date that the certificate requirements of section 263(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Section 146(c) of Pub. L. 103–432 provided that: “The amendments made by this section [amending this section] shall take effect on January 1, 1995.”

Amendment by section 147(e)(1), (4), (5), (f)(3), (4)(A), (6)(A), (B), (E) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3 of this title.

Section 158(a)(2) of Pub. L. 103–432 provided that: “The amendment made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after July 1, 1996.”

Section 13503(c)(2) of Pub. L. 103–66 provided that: “The amendments made by paragraph (1) [amending this section and section 1395oo of this title] shall take effect October 1, 1993.”

Amendment by section 13553(c) of Pub. L. 103–66 provided that: “The amendments made by subsections (a) and (b) [amending this section] shall apply to items furnished on or after such date, with provision that...”

Section 13554(b) of Pub. L. 103–66 provided that: “The amendment made by subsection (a) [amending this sec-
tion] shall apply to services furnished on or after January 1, 1994.''

Section 13356(b) of Pub. L. 103–66 provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 4161(a)(2)(C) of OBRA–1990 [Pub. L. 101–508].''

Section 13356(c) of Pub. L. 103–66 provided that: "The amendments made by this section [amending this section and section 1395rr of this title] shall apply to home health agency cost reporting periods beginning on or after October 1, 1993.''

"The amendments made by paragraph (1) [amending this section and section 1395rr of this title] shall apply with respect to services furnished on or after April 1, 1990, see section 6114(f) of Pub. L. 101–239, set out as a note under section 1395s of this title.

Section 6115(d) of Pub. L. 101–239 provided that: "The amendments made by this section [amending this section and sections 1395y, 1395aa, 1395b, 1396a, and 1396n of this title] shall apply to screening pap smears performed on or after July 1, 1990.''

Amendment by section 6115(a)(2) of Pub. L. 101–239 applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989, with additional provisions regarding applicability of the increase under section 1395y(c)(2)(C) of this title, see section 6131(c) of Pub. L. 101–239, set out as a note under section 1395s of this title.

Section 6114(b) of Pub. L. 101–239 provided that: "The amendments made by subsection (a) [amending this section and section 1395rr of this title] shall apply to erythropoietin furnished on or after January 1, 1994.''

**Effective Date of 1990 Amendment**


Amendment by section 4152(a)(2) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4152(a)(3) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Amendment by section 4153(b)(2)(C) of Pub. L. 101–508 provided that: "The amendments made by subparagraphs (A) and (B) of this section and section 1395s of this title shall apply to items furnished on or after July 1, 1991.

Amendment by section 4155(a), (d) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395s of this title.

Amendment by section 4161(a)(1), (2), (5) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395s of this title.

Amendment by section 4162(b)(5) of Pub. L. 101–508 provided that: "This subsection [amending this section and section 1395s of this title and enacting provisions set out as a note below] shall take effect on October 1, 1991, except that the amendment made by paragraph (A) [amending this section and section 1395s of this title] shall apply to items furnished on or after October 1, 1991.''

Amendment by section 4162(a) of Pub. L. 101–508 applicable to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(a) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395s of this title.

Amendment by section 4201(d)(3)(i) of Pub. L. 101–508 provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1395rr of this title] shall apply to items and services furnished on or after July 1, 1991.''


**Effective Date of 1989 Amendments**

Amendment by section 6122(e)(1) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6122(e)(4) of Pub. L. 101–239, set out as a note under section 1395s of this title.

Amendment by section 6113(e) of Pub. L. 101–239 applicable to services furnished on or after July 1, 1990, see section 6113(e) of Pub. L. 101–239, set out as a note under section 1395s of this title.

Amendment by section 6114(a), (d) of Pub. L. 101–239 applicable to services furnished on or after Apr. 1, 1990, see section 6114(f) of Pub. L. 101–239, set out as a note under section 1395s of this title.

Section 6115(d) of Pub. L. 101–239 provided that: "The amendments made by this section [amending this section and sections 1395y, 1395aa, 1395b, 1396a, and 1396n of this title] shall apply to screening pap smears performed on or after July 1, 1990.''

Amendment by section 6115(a)(2) of Pub. L. 101–239 applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989, with additional provisions regarding applicability of the increase under section 1395y(c)(2)(C) of this title, see section 6131(c) of Pub. L. 101–239, set out as a note under section 1395s of this title.

"The amendments made by subsection (a) [amending this section and section 1395rr of this title] shall apply to erythropoietin furnished on or after January 1, 1994.''

**Effective Date of 1988 Amendment**

Section 8423(b) of Pub. L. 100–647 provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after January 1, 1989.''

Section 8424(b) of Pub. L. 100–647 provided that: "The amendment made by subsection (a) [amending this section] shall become effective with respect to services provided after December 31, 1988.''

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 606(g)(1) of Pub. L. 100–360, set out as a note under section 704 of this title.

Amendment by section 104(d)(4) of 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 1395s of this title.

Amendment by section 202(a) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395s of this title.

Amendment by section 203(b), (e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(a) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(b) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Amendment by section 206(b) of Pub. L. 100–360 applicable to services furnished in cases of initial periods of home health services beginning on or
of vaccine which might otherwise not have occurred, the costs of illnesses and nursing home days avoided, and other relevant factors, except that extended life for beneficiaries shall not be considered to reduce the cost effectiveness of the vaccine.''

Section 4072(e) of Pub. L. 100–203 provided that: ''(1) The amendments made by this section [amending this section and sections 1395h, 1395n, and 1396n of this title] shall become effective (if at all) in accordance with paragraph (2).

(2) (A) The Secretary of Health and Human Services (in this paragraph referred to as the 'Secretary'), shall establish a demonstration project to begin on October 1, 1988, to test the cost-effectiveness of furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section to a sample group of medicare beneficiaries.

(B) (i) The demonstration project under subparagraph (A) shall be conducted for an initial period of 24 months. Not later than October 1, 1990, the Secretary shall report to the Congress on the results of such project. If the Secretary finds, on the basis of existing data, that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is cost-effective, the Secretary shall include such finding in such report, such finding shall become effective on the first day of the first month to begin after such report is submitted to the Congress unless the report contains a finding by the Secretary that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is not cost-effective (in which case the amendments made by this section shall not become effective).


Section 4073(b) of Pub. L. 100–203 provided that: ''(1) The amendments made by this section [amending this section and sections 1395h and 1395n of this title] shall become effective on January 1, 1988.

(2) The provisions of subsection (e) of section 4072 of this subpart [section 4072(e) of Pub. L. 100–203, set out below] shall apply to this section [amending this section] as if it were in effect on or after the date of enactment of this Act [Dec. 22, 1987].''

Section 4073(c) of Pub. L. 100–203 provided that: ''(A) The amendments made by this section [amending this section and sections 1395h and 1395n of this title] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

(B) The Secretary of Health and Human Services shall implement the amendments made by subsection (a) so as to ensure that there is no additional cost to the medicare program by reason of such amendments.''

Section 4073(d) of Pub. L. 100–203 provided that: ''(1) The provisions of this section [amending this section and sections 1395h and 1395n of this title] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

(2) In conducting the demonstration project pursuant to paragraph (1), in order to determine the cost effectiveness of including influenza vaccine in the medicare program, the Secretary of Health and Human Services is required to conduct a demonstration of the provision of influenza vaccine as a service for medicare beneficiaries and to expend $25,000,000 each year of the demonstration project for this purpose. In conducting this demonstration, the Secretary is authorized to purchase in bulk influenza vaccine and to distribute it in a manner to make it widely available to medicare beneficiaries, to develop projects to provide vaccine in the same manner as other covered medicare services in large scale demonstration projects, including statewide projects, and to engage in other appropriate use of moneys to provide influenza vaccine to medicare beneficiaries and evaluate the cost effectiveness of its use.

In determining cost effectiveness, the Secretary shall consider the direct cost of the vaccine, the utilization...
to implement such amendments are promulgated by such date, except as otherwise specifically provided in section 1395I–3 of this title, see section 4204(a) of Pub. L. 98–21, as amended, set out as an Effective Date note under section 1395I–3 of this title.

**Effective Date of 1986 Amendments**

Section 9335(c)(4) of Pub. L. 99–509 provided that: “The amendments made by this subsection [amending this section and section 1395u of this title] shall apply to hospitals as of one year after the date of the enactment of this Act [Oct. 21, 1986].”

Amendment by section 9333(a)(3) of Pub. L. 99–509 provided that: “The amendments made by this subsection [amending this section and section 1395ff of this title] take effect on the date of the enactment of this Act [Oct. 21, 1986].”

Amendment by section 9330(b), (c), (f) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9330(d), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Section 9335(c)(2) of Pub. L. 99–509 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to immunosuppressive drugs furnished on or after January 1, 1987.”

Section 9338(b) of Pub. L. 99–509 provided that: “The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1987.”

Amendment by section 9337(d) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Section 9338(b) of Pub. L. 99–509 provided that: “The amendments made by this section [amending this section and section 1395a of this title] shall apply to services furnished on or after January 1, 1987.”

Section 9107(c)(2) of Pub. L. 99–272 provided that: “The amendments made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985.”

Section 9322(b) of Pub. L. 99–509 provided that: “The amendments made by subsection (a) [amending this section] shall be applied as though they were originally included in the Social Security Amendments of 1984 [Pub. L. 98–369].”

Section 9322(a)(2) of Pub. L. 99–272 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 1984.”


Section 9202(a) of Pub. L. 99–272 provided that: “The amendments made by subparagraph (A) [amending this section] shall be effective as if it had been originally included in the Social Security Amendments of 1983 [Pub. L. 98–21].”

**Effective Date of 1984 Amendments**

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395u of this title.

Section 2335(b) of Pub. L. 98–369 applicable to plans of care established on or after July 18, 1984, see section 2335(b) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Section 2341(c) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2341(c) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Section 2342(a) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2342(a) of Pub. L. 98–369, set out as a note under section 1395f of this title.

**Effective Date of 1983 Amendments**

Amendment by section 602(d) of 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 602(d) 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 in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, to which such amendment relates, see section 309(c)(1) of Pub. L. 97–448, set out as a note under section 426 of this title.

**Effective Date of 1982 Amendment**

Amendment by section 101(a)(2) of Pub. L. 97–248 applicable to cost reporting periods beginning on or after Oct. 1, 1982, see section 101(a)(2) of Pub. L. 97–248, set out as an Effective Date note under section 1395ww of this title.

Section 102(b) of Pub. L. 97–248, as amended by Pub. L. 98–21, title VI, §605(a), Apr. 20, 1983, 97 Stat. 169, pro-
vided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1981.

Section 103(b) of Pub. L. 97–248 provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to contracts entered into or renewed on or after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act (this subchapter) to a hospital or skilled nursing facility resulting from such amendment shall be imposed only in proportion to the part of the period which occurs after September 30, 1982."

Section 105(b) of Pub. L. 97–248 provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after the date of the enactment of this Act [Sept. 3, 1982]."

Section 106(b) of Pub. L. 97–248 provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to any costs incurred under title XVIII of the Social Security Act [this subchapter], except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act [Sept. 3, 1982] pursuant to the final court order affirmed by a United States Court of Appeals."

Section 107(b) of Pub. L. 97–248 provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to costs incurred after the date of the enactment of this Act [Sept. 3, 1982]."


Section 109(c)(3) of Pub. L. 97–248 provided that: "The amendment made by subsection (b)(1) [amending this section] shall not apply to contracts entered into before the date of the enactment of this Act [Sept. 3, 1982]."

Amendment by section 122(d) 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.


(2) Except as otherwise provided in this section, any amendment to the Social Security Act [this chapter] or the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [Title 26, Internal Revenue Code] made by this section (other than subsection (d) [amending this section and sections 1385g, 1385cc, and 1385gg of this title and section 162 of Title 26] shall be effective as if it had been originally included as a part of that provision of the Social Security Act or Internal Revenue Code of 1986 to which it relates, as such provision of such Act or Code was amended by the Omnibus Budget Reconciliation [Reconciliation] Act of 1981 [Pub. L. 97–35]."

(3) The amendments made by subsection (d) [amending this section and sections 1385u, 1385bb, 1385cc, and 1385gg of this title] shall take effect upon enactment [Sept. 3, 1982]."

Amendment by section 148(b) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1986, see section 148(b) of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

**Effective Date of 1981 Amendment**

Section 2102(b)(1) of Pub. L. 97–35 provided that: "The amendments made by subsection (a) [amending this section], shall apply to services provided on or after the first day of the first month beginning after the date of the enactment of this Act [Aug. 13, 1981]."

Amendment by section 2121(c), (d) 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(c) of Pub. L. 97–35, set out as a note under section 1395x of this title.

Section 2141(c) of Pub. L. 97–35 provided that: "(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

Section 2141(b) of Pub. L. 97–35, as amended by Pub. L. 97–248, § 1128(c)(1), Sept. 3, 1982, 96 Stat. 367, provided that:

"(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

Section 2141(b) of Pub. L. 97–35, as amended by Pub. L. 97–248, title I, § 1128(c)(1), Sept. 3, 1982, 96 Stat. 367, provided that:

(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

For effective date, savings, and transitional provisions relating to amendment by section 2198(c)(9) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

**Effective Date of 1980 Amendments**

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395f of this title.

Section 902(a) of Pub. L. 96–499 provided that: "The amendments made by this section [amending this section and sections 1320c–7 and 1396a of this title] shall become effective on the date of [probably should be "at"] which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980]."

Section 930(a) of Pub. L. 96–499 provided that:

(1) the amendments made by this section [amending this section, sections 1385c, 1385d, 1385g, 1385h, 1395k, 1395n, and 1395m of this title, and section 211(f) of Title 45, Railroads, and repealing section 1395m of this title] shall become effective with respect to services furnished on or after July 1, 1981, except that the amendments made by subsections (n)(1) and (o) [amending this section and section 1395h of this title] shall become effective on the date of the enactment of this Act [Dec. 5, 1980]."

(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1) [amending this section], will be made not later than June 30, 1981."

Amendment by section 931(c), (d) 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.

Amendment by section 933(c)–(e) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.
Amendment by section 936(a) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Section 937(c) of Pub. L. 96–499, as amended by Pub. L. 98–369, div. B, title III, §2354(c)(1)(B), July 18, 1984, 98 Stat. 1102, provided that: “The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 1981.”

Section 938(b) of Pub. L. 96–499 provided that: “The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1981.”

Section 941(c)(1) of Pub. L. 96–499 provided that: “The amendments made by subsection (a) [amending this section and section 1396c of this title] shall apply with respect to cost accounting periods beginning on or after October 1, 1978. A hospital’s election under section 1396d(b)(7)(A) of the Social Security Act [subsec. (b)(7)(A) of this section] (as administered in accordance with section 15 of Public Law 93–233) as of September 30, 1978, shall constitute such hospital’s election under such section (as amended by subsection (a)(1)) on and after October 1, 1978, until otherwise provided by the hospital.”

Section 951(c) of Pub. L. 96–499 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 furnished after the first day of 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 Amendments

Section 501(c) of Pub. L. 95–216 provided that: “The amendments made by this section [amending this section and section 1396u of this title] shall be effective in the case of items and services furnished after the date of the enactment of this Act [Dec. 20, 1977].”

Amendment by Pub. L. 95–210 applicable to services rendered on or after the first day of the third calendar month which begins after Dec. 31, 1977, see section 1(a) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Amendment by section 3(a)(2) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 19(b)(1) of Pub. L. 95–142 effective with respect to operation of a hospital, skilled nursing facility, or intermediate care facility on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established under section 1320a(a) of this title for that type of health services facility, except that for other types of facilities or organizations effective with respect to operations on and after the first day of its first fiscal year which begins after such date as the Secretary determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization, see section 18(c)(2) of Pub. L. 95–142, set out as a note under section 1396a of this title.

Section 21(c)(1) of Pub. L. 95–142 provided that: “The amendments made by subsection (a) [amending this section] shall be effective after the first day of the first calendar quarter which begins more than six months after the date of enactment of this Act [Oct. 25, 1977].”

Effective Date of 1975 Amendment

Section 106(b) of Pub. L. 94–182 provided that: “Subject to subsection (c) [enacting provisions set out below], the amendment made by subsection (a) [amending this section] shall be effective the first day of the sixth month which begins after the date of enactment of this Act [Dec. 31, 1975].”

Section 112(d) of Pub. L. 94–182 provided that: “The amendments made by this section [amending this section and sections 1320c–17 and 1395g of this title] shall be effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after the date of enactment of this Act [Dec. 31, 1975].”

Effective Date of 1972 Amendment

Amendment by section 211(b), (c)(2) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1385f of this title.

Section 223(h) of Pub. L. 92–603 provided that: “The amendments made by this section [amending this section and section 1386ccc of this title] shall be effective with respect to accounting periods beginning after December 31, 1972.”

Section 227(g) of Pub. L. 92–603 provided that: “The amendments made by this section [amending this section and sections 1395f, 1395k, 1395n, 1395u, and 1395ccc of this title] shall apply with respect to accounting periods beginning after June 30, 1973.”

Section 234(i) of Pub. L. 92–603 provided that: “The amendments made by this section [amending this section and sections 1395f, 1395k, 1395n, 1395u, and 1395ccc of this title] shall apply with respect to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month in which this Act is enacted [October 1972].”

Section 246(c) of Pub. L. 92–603 provided that: “The amendments made by this section [amending this section and section 1396 of this title] shall be effective July 1, 1973.”

Section 251(d) of Pub. L. 92–603, as amended by Pub. L. 93–233, §17(a), Dec. 31, 1973, 87 Stat. 967, provided that:

“(1) The amendments made by subsection (a) [amending this section and sections 1395f and 1395k of this title] shall apply with respect to services furnished on or after July 1, 1973.

“(2) The amendments made by subsection (b) [amending this section and section 1395n of this title] shall apply with respect to services furnished on or after the date of enactment of this Act [Oct. 30, 1972].

“(3) The amendments made by subsection (c) [amending this section] shall be effective with respect to accounting periods beginning after the month in which there are promulgated, by the Secretary of Health, Education, and Welfare, final regulations implementing the provisions of section 1381(v)(b) of the Social Security Act [subsec. (v)(5) of this section].”

Section 252(b) of Pub. L. 92–603 provided that: “The amendment made by subsection (a) [amending this section] shall apply only with respect to items furnished on or after the date of the enactment of this Act [Oct. 30, 1972].”

Amendment by section 256(b) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1385f of this title.

Section 264(b) of Pub. L. 92–603 provided that: “The amendment made by subsection (a) [amending this section] shall be effective on or after the date of the enactment of this Act [Oct. 30, 1972].”

Section 273(b) of Pub. L. 92–603 provided that: “The amendments made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973.”
Section 276(b) of Pub. L. 92–603 provided that: "The amendments made by this section [amending this section] shall apply with respect to accounting periods beginning after December 31, 1972.''

Amendment by section 283(a) of Pub. L. 92–603 to apply with respect to services rendered after Dec. 31, 1972, see section 283(c) of Pub. L. 92–603, set out as a note under section 1395n of this title.

**Effective Date of 1966 Amendment**

Section 127(c) of Pub. L. 90–248 provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395y of this title] shall apply with respect to services furnished after December 31, 1967.''

Amendment by section 132(a), (b), (c)(9)(C), (10), (11) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 132(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Section 134(b) of Pub. L. 90–248 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to services furnished after December 31, 1967.''

Amendment by section 143(a) of Pub. L. 90–248 effective July 1, 1966, see section 143(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 144(e) of Pub. L. 90–248 provided that: "The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968.''

**Effective Date of 1966 Amendment**


**Prompt Implementation of Amendments by Pub. L. 105–277**


"(1) IN GENERAL.—The Secretary of Health and Human Services shall promptly issue (without regard to chapter 8 of title 5, United States Code) such regulations or program memoranda as may be necessary to effect the amendments made by this section [amending this section, sections 1395d(e) and 1395ff of this title, and provisions set out as notes under section 1395ff of this title] for cost reporting periods beginning during fiscal year 1999.

"(2) USE OF PAYMENT AMOUNTS AND LIMITS FROM PUBLISHED TABLES.—

"(A) PER BENEFICIARY LIMITS.—In effecting the amendments made by subsection (a) [amending this section] for cost reporting periods beginning in fiscal year 1999, the ‘median’ referred to in section 1861(v)(1)(L)(v)(I) of the Social Security Act [subsec. (v)(1)(L)(v)(I) of this section] for such periods shall be the national standardized per beneficiary limitation specified in Table 3C published in the Federal Register on August 11, 1998 (63 FR 42925) and the ‘standardized regional average of such costs’ referred to in section 1861(v)(1)(L)(v)(I) of such Act [subsec. (v)(1)(L)(v)(I) of this section] for such periods shall be the sum of the labor and nonlabor component of the national standardized per beneficiary limitation specified in Table 3C published in the Federal Register on that date (63 FR 42925) and as subsequently corrected, multiplied by 5%, adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on August 11, 1998 (63 FR 42926–42933).

"(B) PER VISIT LIMITS.—In effecting the amendments made by subsection (b) [amending this section] for cost reporting periods beginning in fiscal year 1999, the limits referred to in section 1861(v)(1)(L)(v)(V) of such Act [subsec. (v)(1)(L)(v)(V) of this section] for cost reporting periods beginning during such fiscal year shall be equal to the per visit limits as specified in Table 4A published in the Federal Register on August 11, 1998 (63 FR 42925) and as subsequently corrected, multiplied by 5%, and adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on August 11, 1998 (63 FR 42926–42933)."

**Conforming References to Previous Part C**

Section 4002(p)(1) of Pub. L. 105–33 provided that: "Any reference in law (in effect before the date of the enactment of this Act [Aug. 5, 1997]) to part C of title XVIII of the Social Security Act [part C of this subchapter] is deemed a reference to part D of such title (this part) (as in effect after such date)."

**Deadline for Publication of Determination on Coverage of Screening Barium Enema**

Section 4106(a)(2) of Pub. L. 105–33 provided that: "Not later than the earlier of the date that is January 1, 1998, or 90 days after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall publish notice in the Federal Register with respect to the determination under paragraph (1)(D) of section 1861(v)(1)(L)(V) of such Act (42 U.S.C. 1395x(pp)), as added by paragraph (1), on the coverage of a screening barium enema as a colorectal cancer screening test under such section."

**Establishment of Outcome Measures for Medicare Beneficiaries With Diabetes**

Section 4105(c) of Pub. L. 105–33 provided that: "(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glycated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes mellitus.

"(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of Medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under paragraph (1), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the Medicare program."

**Vaccines Outreach Expansion**

Section 4107 of Pub. L. 105–33 provided that:

"(a) EXTENSION OF INFECTIOUS AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in Medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

"(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each fiscal year 1998 through 2002, $8,000,000 for the Campaign described in subsection (a). Of the amount so appropriated to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund."

**Study on Preventive and Enhanced Benefits**

Section 4108 of Pub. L. 105–33 provided that:

"(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sci-
ences, and as appropriate in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive or other benefits provided to Medicare beneficiaries under title XVIII of the Social Security Act [this subchapter]. The analysis shall consider both the short term and long term benefits, and costs to the Medicare program, of such expansion or modification.

"(b) REPORT.—

"(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(2) CONTENTS.—Such report shall include specific findings with respect to coverage of at least the following benefits:

"(A) Nutrition therapy services, including parenteral and enteral nutrition and including the provision of such services by a registered dietitian.

"(B) Skin cancer screening.

"(C) Medically necessary dental care.

"(D) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

"(E) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

"(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as the Secretary determines necessary for the conduct of the study by the National Academy of Sciences under this section.

UTILIZATION GUIDELINES

Section 4513(c) of Pub. L. 105–33 provided that: "The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of preventive services and are medically necessary based on the most recent Goldsmith Modification, including regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of advanced life support services—

"(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

"(2) The volunteer ambulance service involved—

"(A) is certified as qualified to provide ambulance services for purposes of such section,

"(B) provides only basic life support services at the time of the intercept, and

"(C) is prohibited by State law from billing for any services.

"(3) The entity supplying the ALS intercept services—

"(A) is certified as qualified to provide such services under the Medicare program under title XVIII of the Social Security Act [this subchapter], and

"(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether such recipients are Medicare beneficiaries.

For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in the Federal Register on February 22, 1992 (57 Fed. Reg. 6725))."

[Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §412(b)], Nov. 29, 1999, 113 Stat. 1538, 1531A–377, provided that: "The amendment made by subsection (a) of section 4531(c) of Pub. L. 105–33, set out above] takes effect on January 1, 2000, and applies to ALS intercept services furnished on or after such date."]

NO EXCEPTIONS PERMITTED BASED ON AMENDMENT TO SUBSECTION (V)(1)(L)

Section 4613(b) of Pub. L. 105–33 provided that: "The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) [amending this section] in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395l(v)(1)(L)(ii))."

STUDY ON DEFINITION OF HOMEBOUND

Section 4613 of Pub. L. 105–33 provided that:

"(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the Medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

"(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

REVISIONS OF COVERAGE FOR IMMUNOSUPPRESSIVE DRUG THERAPY

Section 160(c) of Pub. L. 103–432 provided that: "The Secretary of Health and Human Services may administer section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395l(s)(2)(J)) in a manner such that the months of coverage provided is the same as the number of months described in such section.

FREEZE IN PER VISIT COST LIMITS FOR HOME HEALTH PROVIDERS

Section 1386(e)(1) of Pub. L. 103–66 provided that: "The Secretary of Health and Human Services shall not provide for any change in the per visit cost limits for home health services under section 1861(v)(1)(L) of such Act [subsec. (v)(1)(L) of this section] for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, except as may be necessary to take into account the amendment made by subsection (b)(1) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1861(v)(1)(L)(ii) of such Act to the payment limits for such services during such cost reporting periods.

STUDY AND REPORT ON EFFECTS OF COVERAGE OF OSTEOPOROSIS DRUGS

Section 4166(b) of Pub. L. 101–508 directed Secretary of Health and Human Services to conduct a study analyzing the effects of coverage of osteoporosis drugs under part B of this subchapter on health of individuals enrolled under such part and utilization of inpatient hospital and extended care services by such individuals, and, by not later than Oct. 1, 1994, to submit a report to Congress on such study, which was to include recommendations regarding expansion of coverage under the Medicare program of items and services for individuals with post-menopausal osteoporosis as the Secretary considered appropriate.
PRODUCTIVITY SCREENING GUIDELINES APPLICATION TO STAFF IN RURAL HEALTH CLINICS

Section 4161(b)(3) of Pub. L. 101–508 provided that: “In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioners).”

DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES

Section 4207(c), formerly 4207(c), of Pub. L. 101–508, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (9), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–362, title VI, §601(b)(2), Nov. 10, 1998, 112 Stat. 3266, directed Secretary of Health and Human Services to develop a proposal to modify the current system under which payment is made for home health services under this subchapter or a proposal to replace such system with, among other things, payment made on the basis of prospectively determined rates, with Secretary to submit to Congress by not later than Apr. 1, 1988, the research findings upon which the proposal was to be based, and directed Prospective Payment Assessment Commission to submit to Congress by not later than Mar. 1, 1994, an analysis of and comments on the proposal.

APPLICATION OF BUDGET-NEUTRAL BASIS

Section 4207(d)(2), formerly 4207(d)(2), of Pub. L. 101–508, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: “In updating the wage index for establishing limits under section 1861(v)(1)(L)(iii) of the Social Security Act (subsec. (v)(1)(L)(iii) of this section), the Secretary shall ensure that aggregate payments to home health agencies under title XVIII of such Act [this subchapter] will be allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital.”

(Section 6205(a)(2) of Pub. L. 101–239 provided that: “Paragraph (1)(A) [set out above] shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act (Dec. 19, 1989) and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A) [set out as a note under section 1395w(e) of this title].”)

DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION

Section 6213(e) of Pub. L. 101–239 directed Secretary of Health and Human Services, not later than 60 days after Dec. 19, 1989, in consultation with the Director of the Office of Rural Health Policy, to disseminate to health care facilities and to the chief executive officer, chief health officer, and chief human services officer of each State, applications and other necessary information to enable such a facility to apply for designation as a rural health clinic for the purposes of this subchapter and subchapter XIX of this chapter.

TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS

Section 6213(f) of Pub. L. 101–239 provided that: “The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2) of the Social Security Act [subsec. (aa)(2) of this section] if the facility is located on or after the date of the enactment of this Act (Dec. 19, 1989) and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A) [set out as a note under section 1395w(e) of this title].”

CONTINUATION USE OF HOME HEALTH WAGE INDEX IN EFFECT PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991

Section 6220 of Pub. L. 101–239 provided that: “Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social Security Act [subsec. (v)(1)(L)(iii) of this section], the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of the Social Security Act [this subchapter] with respect to services furnished by home health agencies, continue to utilize the wage index that was in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991.”

PAYMENT FOR MEDICAL ESCORT OR MEDICAL ATTENDANT ON COMMERCIAL AIRLINER ALLOWED

Section 6227 of Pub. L. 101–467 provided that:
“(a) IN GENERAL.—The Secretary of Health and Human Services shall provide that in cases where (as of the date of the enactment of this Act [Nov. 10, 1988]) transportation on a commercial airliner is covered under section 1861(s)(7) of the Social Security Act [subsec. (c)(7) of this section], the Secretary shall also provide for payment for medically necessary services of a medical escort or medical attendant.

“(b) Effective Period.—Subsection (a) shall apply to payment for services furnished during the 5-year period beginning on July 1, 1989.

**Skilled Nursing Facility; Access and Visitation Rights**

Section 411(i)(2)(E) of Pub. L. 100–360 provided that: ‘‘Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1819(c) of such Act [see Effective Date note set out under section 1395i–3 of this title, section 1861(i) of the Social Security Act [subsec. (j) of this section] is deemed to include the requirement described in section 1819(c)(3)(A) of such Act [section 1396–1(c)(3)(A) of this title] (as added by section 4201(a)(3) of OBRA).’’

**Moratorium on Prior Authorization for Home Health and Post-Hospital Extended Care Services**

Section 9338(e) of Pub. L. 100–203 provided that: ‘‘The Secretary of Health and Human Services shall not implement any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under part A or part B of title XVIII of the Social Security Act [part A or B of this subchapter] at any time prior to six months after the date on which the Secretary receives the report required under section 9305(k)(4) of the Omnibus Budget Reconciliation Act of 1986 [section 9305(k)(4) of Pub. L. 99–509, set out below].’’

**Delay in Publishing Regulations with Respect to Deeming Status of Entities**

Section 4089(f) of Pub. L. 100–203 provided that: ‘‘The Secretary of Health and Human Services shall not implement any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under part A or B of title XVIII of the Social Security Act [part A or B of this subchapter] if the Secretary determines that such authorization program will be burdensome to entities that provide such services, will result in reduced access to care for beneficiaries, or will result in significant delays in the timely delivery of such services.’’

**Development of Uniform Needs Assessment Instrument**

Section 9306(b) of Pub. L. 99–509 directed Secretary of Health and Human Services to develop a uniform needs assessment instrument that could be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating individual’s need for post-hospital extended care services, home health services, and long-term care services of health-related or supportive nature, and further provided for creation of advisory panel to assist Secretary and for a report to Congress not later than Jan. 1, 1989.

**Prior and Concurrent Authorization Demonstration Project**

Section 9306(k) of Pub. L. 99–509 directed Secretary of Health and Human Services to conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of this subchapter, which was to include at least four projects and was to be initiated by not later than Jan. 1, 1987, under which the Secretary was to monitor the acceptance of individuals entitled to benefits under this subchapter by providers to ensure that the placement of such individuals was not delayed until the results of prior and concurrent review were known, and further directed Secretary to evaluate the demonstration program and report to Congress on such evaluation no later than Feb. 1, 1989.

**Considerations in Establishing Limits on Payment for Home Health Services**

Section 9313(b) of Pub. L. 99–509 provided that: ‘‘In establishing limitations under section 1861(v)(1)(L) of the Social Security Act [subsec. (v)(1)(L) of this section] on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

1. base such limitations on the most recent data available, which data may be revised from time to time without changing the effective date of the limitations.

2. take into account the changes in costs of home health agencies for services described in section 1395x(s)(2)(K) of this title that result from the Secretary’s changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements established before, on, or after July 1, 1986.’’

**Comptroller General Study and Report on Cost Limits for Home Health Services**

Section 9313(c) of Pub. L. 99–509 directed Comptroller General to study and report to Congress, not later than Feb. 1, 1988, on appropriate adjustments of payment to Medicare beneficiaries of applying the per visit cost limits for home health services under subsec. (v)(1)(L) of this section on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and appropriateness of the percentage limits so established.

**Reduction in Payment to Avoid Duplicate Payment for Services of Physician Assistants**

Section 9338(d) of Pub. L. 99–509 directed Secretary of Health and Human Services to reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under this subchapter to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1395x(s)(2)(K) of this title, prior to repeal by Pub. L. 101–508, title IV, § 4002(f), Nov. 5, 1990, 104 Stat. 1388–36, effective as if included in the enactment of Pub. L. 99–509.

**Study and Report on Payments for Physician Assistants**

Section 9338(e) of Pub. L. 99–509 directed Secretary to report to Congress, by Apr. 1, 1988, concerning adjustments to amount of payment made, under part B for services described in subsec. (s)(2)(K) of this section, to the extent the additional cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

**Cost Limits for Routine Services for Urban and Rural Hospital-Based Skilled Nursing Facilities; Cost Reporting Periods Beginning On or After October 1, 1982, and Prior to July 1, 1984**

Section 2319(d) of Pub. L. 98–369 provided that: ‘‘Notwithstanding limits on the cost of skilled nursing facilities which may have been issued under section 1861(v) of the Social Security Act [subsec. (v) of this section] prior to the date of the enactment of this Act [July 18, 1984], in the case of cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, the cost limits for routine services for urban and rural hospital-based skilled nursing facilities shall be 112 percent of the mean of the respective routine costs for urban and rural hospital-based skilled nursing facilities.’’

**Study and Report Relating to Requirements That Core Services Be Furnished Directly by Hospices**

Section 234(d) of Pub. L. 98–369 directed Secretary of Health and Human Services to conduct a study of ne-
cessity and appropriateness of requirements that certain "core" services be furnished directly by a hospice, as required under subsection (d)(2)(A)(ii)(I) of this section and report results of such study to Congress with the report required under section 122(c)(1)(B)(ii)(I) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), set out as a note under section 1395f of this title.

REPORT ON EFFECT OF 1983 AMENDMENT ON HOSPITAL-BASED SKILLED NURSING FACILITIES

Section 605(b) of Pub. L. 98–21 directed Secretary of Health and Human Services, prior to Dec. 31, 1983, to complete a study and report to Congress with respect to (1) effect which implementation of section 102 of the Tax Equity and Fiscal Responsibility Act of 1982, amending this section, would have on hospital-based skilled nursing facilities, given the differences (if any) in patient populations served by such facilities and by community-based skilled nursing facilities and (2) impact on skilled nursing facilities of hospital prospective payment systems, and recommendations concerning payment of skilled nursing facilities.

Section 2319(e) of Pub. L. 98–369 directed Secretary of Health and Human Services to submit to Congress, prior to Dec. 1, 1984, the report required under section 605(b) of the Social Security Amendments of 1983 (Pub. L. 97–21), set out above.

ELIMINATION OF PRIVATE ROOM SUBSIDY

Section 111 of Pub. L. 97–248 provided that:

"'(a) The Secretary of Health and Human Services shall, pursuant to section 1861(v)(2) of the Social Security Act [subsec. (v)(2) of this section], not allow as a reasonable cost the estimated amount by which the costs incurred by a hospital or skilled nursing facility for nonmedically necessary private accommodations for Medicare beneficiaries exceeds the costs which would have been incurred by such hospital or facility for semiprivate accommodations.

"'(b) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) as may be necessary to implement subsection (a) as determined under the provisions of title XIX, of such Act.'"

REGULATIONS REGARDING ACCESS TO BOOKS AND RECORDS

Section 952(b) of Pub. L. 96–499, as added by Pub. L. 97–248, title I, §127(h), Sept. 3, 1982, 96 Stat. 368, provided that the Secretary of Health and Human Services first publishes final regulations prescribing the criteria and procedures described in the last sentence of section 1861(v)(1)(D) of the Social Security Act [subsec. (v)(1)(D) of this section] by January 1, 1982, after providing a period of not less than 60 days for public comment on proposed regulations, the amendment made by subsection (a) [amending this section] shall only apply to books, documents, and records relating to services furnished (pursuant to contract or subcontract) on or after the date on which final regulations of the Secretary are first published.

COMPLIANCE WITH THE LIFE SAFETY CODE OR STATE FIRE AND SAFETY CODE

Section 919(b) of Pub. L. 96–499 provided that: "Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [subsec. (j)(13) of this section] on the day before the date of the enactment of this Act [Dec. 5, 1980] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967, or 23d edition, 1973), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13), be considered (for purposes of titles XVIII or XIX or this Act [this subchapter or subchapter XIX of this chapter]) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.''

Section 106(c) of Pub. L. 98–369 provided that: "Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [subsec. (j)(13) of this section] on the day preceding the first day referred to in subsection (b) [enacting provisions set out as a note under this section] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII and XIX of such Act [subchapters XVIII and XIX of this chapter]) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.''

PRIVATE, NONPROFIT HEALTH CARE CLINICS QUALIFYING, AS OF JULY 1, 1977, AS RURAL HEALTH CLINICS

Section 1(e) of Pub. L. 95–210 provided that: "Any private, nonprofit health care clinic that—

"'(1) on July 1, 1977, was operating and located in an area which on that date (A) was not an urbanized area (as defined by the Bureau of the Census) and (B) had a supply of physicians insufficient to meet the needs of the area (as determined by the Secretary), and

"'(2) meets the definition of a rural health clinic under section 1861(aa)(2) [subsec. (aa)(2) of this section] or section 1905(l) of the Social Security Act [section 1396d(l) of this title], except for clause (1) of section 1861(aa)(2) [subsec. (aa)(2) of this section], shall be considered, for purposes of title XVII or XIX, respectively, of the Social Security Act [this subchapter or subchapter XIX of this chapter], as satisfying the definition of a rural health clinic under such section.''

PROCLAMATION OF REGULATIONS DEFINING COSTS CHARGEABLE TO PERSONAL FUNDS OF PATIENTS IN SKILLED NURSING FACILITIES; DATE OF ISSUANCE

Section 21(b) of Pub. L. 95–142 provided that: "The Secretary of Health, Education, and Welfare [now Health and Human Services] shall, by regulation, define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under the provisions of title XVIII [this subchapter] under a State plan approved under the provisions of title XIX [subchapter XIX of this chapter], of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for extended care services as determined under the provisions of title XVIII, or for skilled nursing and intermediate care facility services as determined under the provisions of title XIX, of such Act.'

Section 21(c)(2) of Pub. L. 95–142 provided that: "The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (b) [set out above] within ninety days after the date of enactment of this Act (Oct. 25, 1977)."

HOME HEALTH SERVICES: GRANTS FOR ESTABLISHMENT, OPERATION, STAFFING, ETC., OF PUBLIC AND NONPROFIT PRIVATE AGENCIES AND ENTITIES; PROCEDURES; PAYMENTS; AUTHORIZATION OF APPROPRIATIONS


PAYMENT FOR SERVICE OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL FOR ACCOUNTING PERIODS BEGINNING AFTER JUNE 30, 1975, AND PRIOR TO OCTOBER 1, 1978

Pub. L. 93–233, §15(a)(1), (b)–(d), Dec. 31, 1973, 87 Stat. 965, as amended by Pub. L. 93–388, §7, Aug. 7, 1974, 88 Stat. 622, Pub. L. 94–368, §1, July 16, 1976, 90 Stat. 997, Pub. L. 95–292, §7, June 13, 1978, 92 Stat. 316, provided that for the cost accounting periods beginning after June 30, 1975, and prior to October 1, 1978, subsec. (b) or this section will be administered as if paragraph (7) of subsec. (b) read as follows: “(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (a) the hospital elects to receive any payment due under this title [this subchapter] for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for services under subchapters XVIII and XIX of this chapter [this subchapter] with payment due under this title [this subchapter], the amount payable thereunder with respect to methods of reimbursement for physicians' services under subchapters XVIII and XIX of this chapter [this subchapter] for any expenses incurred for items or services described in section 1395x(nn) of this title, which are not reasonable and necessary for the prevention of illness, (C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness, (D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title, (E) in the case of research conducted pursuant to section 1320–12 of this title, which is not reasonable and necessary to carry out the purposes of that section, (F) in the case of screening mammography, which is performed more frequently than is covered under section 1395x(m)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, and, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(m) of this title, (G) in the case of prostate cancer screening tests (as defined in section 1395x(o)(10) of this title), which are performed more frequently than is covered under such section, (H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title, and (I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation; (2) for which the individual furnished such items or services has no legal obligation to provide.
pay, and which no other person (by reason of such individual’s membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services; (2) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, and in such other cases as the Secretary may specify; (4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians’ services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished); (5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual’s current coverage under such part; (6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C)); (7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), or (H) of paragraph (1)); (8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title; (9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C)); (10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member; (11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household; (12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such dental services if 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; (13) where such expenses are for— (A) the treatment of flat foot conditions and the prescription of supportive devices therefor, (B) the treatment of subluxations of the foot, or (C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care); (14) which are other than physicians’ services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital; (15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of subchapter XI of this chapter) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or (B) which are for services of an assistant at surgery to which section 1395w–4(i)(2)(B) of this title applies; (16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.]; (17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w–3(a) of this title) by an entity other than an entity with which the Secretary has entered into a contract under section 1395w–3(h) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary; (18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(I) of this title and which are furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;
(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;
(20) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of section 1395x(q) of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist; or
(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

(1) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426–1 of this title, and

(2) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(iii) “Large group health plan” defined

In this subparagraph, the term “large group health plan” has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is, or (without regard to entitlement under section 426–1 of this title) would upon application be, entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for benefits under part A of this subchapter under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end
stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997, with respect to periods beginning on or after February 1, 1990, this subparagraph shall be applied by substituting “18-month” for “12-month” each place it appears. Effective for items and services furnished on or after August 5, 1997, with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997, clauses (i) and (ii) shall be applied by substituting “30-month” for “12-month” each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(m) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) “Current employment status” defined

An individual has “current employment status” with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term “employer” includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Conditional payment

(i) Repayment required

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator,
or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity, or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(v) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty proceeding under section 1320a–7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter on another basis—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter), whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list
of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an “employee”) who was furnished a written statement under section 4051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee’s spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A of this subchapter or enrolls under part B of this subchapter, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B of this subchapter unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(c) Drug products

No payment may be made under part B of this subchapter for any expenses incurred for—

1. a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

2. any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 319.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

(e) Item or service by excluded individual or entity; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities;

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395ucc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a) of this section, under part A or part B of this subchapter for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with utilization and quality control peer review organizations

The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a) of this section, and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with utilization and quality control peer review organizations pursuant to part B of subchapter XI of this chapter.


(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1395ww(e)(5)(E) of this title with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.


REFERENCES IN TEXT

Parts A and B of this subchapter, referred to in text, are classified to sections 1395c et seq. and 1395d et seq., respectively, of this title.


Part B of this subchapter XI of this chapter, referred to in subsec. (a)(15) and (g), is classified to section 1320c et seq. of this title.


AMENDMENTS


Subsec. (a)(21). Pub. L. 106–113, § 1000(a)(6) [title III, § 305(b)], inserted “including medical supplies described in section 1395m(a)(5) of this title, but excluding durable medical equipment to the extent provided for in such section” after “home health services”.


Subsec. (a)(14). Pub. L. 101–508, § 4157(c)(1), inserted “‘described services’” services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychological services, and services of a certified registered nurse anesthetist,” after “‘this paragraph’” and struck out before semicolon at end as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e)(1). Pub. L. 101–239, § 6111(d)(2), inserted “‘(D), not including items or services furnished in an emergency room of a hospital’” after “‘(other than an emergency item or service’”.

1988—Subsec. (a)(1)(A). Pub. L. 100–360, § 204(d)(2)(A)(i), substituted “a succeeding subparagraph” for “subparagraph (B), (C), (D), or (E)’’.


Subsec. (a)(6). Pub. L. 100–360, § 205(e)(1)(B), inserted “and, except in the case of in-home care, as is otherwise permitted under paragraph (1)(G)” after “paragraph (1)(C)”.

Subsec. (a)(7). Pub. L. 100–360, § 204(d)(2)(B), inserted “and, except under paragraph (1)(F)” after “‘(1)(B)’.”

Subsec. (a)(15). Pub. L. 100–360, § 4111(d)(4)(D)(i), inserted “‘(including subsequent insertion of an intraocular lens)’” after “‘operation’”.

Subsec. (c). Pub. L. 100–360, § 202(d), designated existing provisions as par. (1), redesignated former par. (1) as par. (2), redesignated former par. (2) as par (2)(B), redesignated former par. (A) as cl. (i), and added par. (2) prohibiting payment for expenses incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days with an exception.

Subsec. (e)(1). Pub. L. 100–360, § 4111(d)(4)(D)(i), as amended by Pub. L. 100–485, § 608(d)(24)(C)(i), designated existing provisions of subsec. (e) as par. (1), redesignated former par. (1) as par. (2A), substituted “‘1395u(j)(2),’” in text, and transferred catchline “Limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities,” substituting “‘(2)’” for the section designation, inserting “‘1395u(j)(2)’, in text, and transferring the text to par. (2) of subsec. (e) of this section.

1987—Subsec. (a)(1)(A). Pub. L. 100–203, § 4085(k)(15), substituted “‘D,’ or ‘E’” for “‘or D’”.

Subsec. (a)(8). Pub. L. 100–203, § 4072(c), inserted “other than shoes furnished pursuant to section 1395x(s)(12) of this title’ before semicolon.


Subsec. (b)(2)(A)(i). Pub. L. 100–203, § 4036(a)(1), substituted “can reasonably be expected to be made under such a plan” for “‘the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this subchapter’.”

Subsec. (b)(4)(B)(i). Pub. L. 100–203, § 4034(a), substituted “‘subsection (b) of section 5000 of the Internal Revenue Code of 1986’” for “‘section 5000(b) of the Internal Revenue Code of 1986’”.

Subsec. (d). Pub. L. 100–93, § 82(c)(1)(A), struck out subsec. (d), which provided that no payment be made under this subchapter for any item or service to an individual by or on behalf of such person.

Subsec. (e). Pub. L. 100–203, § 4036(a)(1), added subpar. (D), which provided that no payment be made under this subchapter for any item or service to an individual by or on behalf of such person.
service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, against any entity (including any physician or provider) which has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a plan.

Subsec. (b)(3)(A)(i). Pub. L. 98–369, §2301(a), struck out “over 64 but” before “under 70 years” in two places.


Subsec. (b)(3)(A)(v). Pub. 97–248, §122(f)(4), inserted “except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C) of this section”.


Subsec. (a)(1). Pub. L. 97–248, §122(f)(1), designated existing provisions as subpars. (A) and (B), in subsec. (A) as so designated inserted exceptions to provisions for items and services described in subpar. (B) or (C), substituted “and” for “or” as the connector between provisions, and added subpar. (C).

Subsec. (a)(2). Pub. L. 97–248, §122(f)(2), added “except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C)”.


Subsec. (a)(4). Pub. L. 97–248, §122(f)(4), inserted “except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C)”.

Subsec. (b)(1). Pub. L. 97–248, §122(b)(2), struck out “or plan” after “service has been made under such a plan.”


Subsec. (d)(1). Pub. L. 97–248, §114(a), substituted “on the basis of information acquired by the Secretary in the administration of the plan” for “on the basis of reports transmitted to him in accordance with section 1320c–6 of this title (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this subchapter)”.

Subsec. (f). Pub. L. 97–248, §122(g)(1), substituted “paragraph (1)(A)” for “paragraph (1)”.


1981—Subsec. (b). Pub. L. 97–35, §214(a), designated existing provisions as par. (1) and added par. (2).
Subsec. (a). Pub. L. 92–603, §256(c), authorized payment under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization.

Subsec. (a)(12). Pub. L. 92–603, §256(c), authorized payment under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization.

Effective Date of 1999 Amendment
Amendment by section 1000(a)(6) [title III, §305(b) of Title 42, The Public Health and Welfare] applicable to payments for services provided on or after Nov. 29, 1999, see section 1000(a)(6) [title III, §305(c) of Pub. L. 106–113, set out as a note under section 1395a of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(10) of Title 42, The Public Health and Welfare] applicable to payments for services provided on or after Nov. 29, 1999, see section 1000(a)(6) [title III, §321(m) of Pub. L. 106–113, set out as a note under section 1395d of this title.

Effective Date of 1997 Amendments
Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services furnished on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date Note; Transfer of Functions note under section 1395–6 of this title.

Amendment by section 412(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 412(c) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 410(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 410(c) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 420(c)(1) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 420(c)(1) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 452(b)(1) of Pub. L. 105–33 applicable to services furnished on or after July 1, 1998, see section 452(b)(1) of Pub. L. 105–33, set out as a note under section 1395–3 of this title.

Amendment by section 4507(a)(2)(B) of Pub. L. 105–33 applicable with respect to contracts entered into on and after Jan. 1, 1998, see section 4507(c) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 451(a)(2)(C) of Pub. L. 105–33 applicable with respect to contracts entered into on and after Jan. 1, 1998, see section 451(c) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 4541(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, including portions of cost reporting periods occurring on or after such date, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 4603(c)(2)(C) of Pub. L. 105–33 applicable to cost reporting periods beginning on or before Oct. 1, 1997, see section 4603(c)(2)(C) of Pub. L. 105–33, set out as a note under section 1395a of this title.
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.

Section 1461(c) of Pub. L. 103–33 provided that: "The amendments made by this section [amending this section] apply to services furnished on or after October 1, 1997.

Section 4632(b) of Pub. L. 103–33 provided that: 'The amendments made by this section [amending this section] apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].'

Section 463(c) of Pub. L. 103–33 provided that: 'The amendments made by this section [amending this section] apply to items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].'

Effective Date of 1994 Amendment
Amendment by section 145(c)(1) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263(b)(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1396m of this title.

Amendment by section 147(e)(6) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Section 151(a)(2)(B) of Pub. L. 103–432 provided that: 'The amendments made by this subsection [amending this section] apply to payments for items and services furnished on or after the date of the enactment of this Act [Oct. 31, 1994].'

Section 151(b)(3)(C) of Pub. L. 103–432 provided that: 'The amendments made by this section [amending this section] shall apply to payments for items and services furnished on or after the date of the enactment of this Act [Oct. 31, 1994].'

Section 151(c)(4) of Pub. L. 103–432 provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–6–66.

Section 151(c)(5), (6) of Pub. L. 103–432 provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–508.

Amendment by section 156(a)(2)(D) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

Section 157(b)(8) of Pub. L. 103–432 provided that: 'The amendments made by this subsection [amending this section] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].'

Effective Date of 1995 Amendment

Amendment by section 13561(d)(1) of Pub. L. 103–66 effective 90 days after Aug. 10, 1993, see section 13561(d)(2) of Pub. L. 103–66, set out as a note under section 1396m of this title.


Amendment by section 13561(d) of Pub. L. 103–66 provided that: 'The amendments made by this section [enacting section 1320–14 of this title and amending this section, section 1396a of this title, and section 552a of Title 5, Government Organization and Employees] shall take effect on January 1, 1994.'

Effective Date of 1990 Amendment
Amendment by section 4153(b)(2)(B) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(b)(2)(C) of Pub. L. 101–508, set out as a note under section 1396x of this title.

Amendment by section 4157(c)(1) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1396x of this title.

Amendment by section 4161(a)(3)(C) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(4) of Pub. L. 101–508, set out as a note under section 1396x of this title.

Amendment by section 4163(d)(2)(A)(i)–(iii), (B) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1396x of this title.

Amendment by section 4163(d)(2)(A)(iv) [amending this section] shall apply to screening mammography performed on or after July 1, 1990.

Effective Date of 1989 Amendments
Amendment by section 6115(b) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1396x of this title.

Amendment by section 6202(b)(1) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Section 6202(c)(2) of Pub. L. 101–239 provided that: 'The amendment made by paragraph (1) [amending this section] shall apply to items and services furnished on or after October 1, 1989.'

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Effective Date of 1988 Amendments
Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(d) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1365 of this title.

Amendment by section 204(d)(2) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1365 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, applicable to items and services furnished on or after Jan. 1, 1990, see section 206(f) of Pub. L. 100–360, set out as a note under section 1365 of this title.

Amendment by section 203(e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(e)(1) of Pub. L. 100–360, set out as a note under section 1365 of this title.
after 60 days after the date of the enactment of this Act [July 1, 1988]."

**Effective Date of 1987 Amendments**

Section 4009(j)(6) of Pub. L. 100–203, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4036(h) of Pub. L. 100–203 provided that: "The amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 9319(a) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Section 4036(a)(2) of Pub. L. 100–203 provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to items and services furnished on or after 30 days after the date of the enactment of this Act [Dec. 22, 1987]."

Section 4063(c)(2) of Pub. L. 100–203 provided that: "The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988." For effective date of amendment by section 4072(c) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395k of this title. Amendment by Pub. L. 100–95 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–95, set out as a note under section 1320a–7 of this title.

**Effective Date of 1986 Amendments**

Section 9319(f) of Pub. L. 99–509 provided that: "(1) Except as provided in paragraph (2), the amendments made by this section [enacting section 5000 of Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395r of this title] shall apply to items and services furnished on or after January 1, 1987.

(2) The amendments made by subsection (c) [amending sections 1395p and 1395r of this title] shall apply to enrollments occurring on or after January 1, 1987."

Amendment by section 9320(h)(1) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(b)(2), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Amendment by section 9343(c)(1) of Pub. L. 99–509 applicable to services furnished after June 30, 1987, see section 9343(b)(2) of Pub. L. 99–509, as amended, set out as a note under section 1395l of this title.

Section 9291(d)(1) of Pub. L. 99–272 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after May 1, 1986."

Amendment by section 9307(a) of Pub. L. 99–272 applicable to services performed on or after Apr. 1, 1986, see section 9307(e) of Pub. L. 99–272, set out as a note under section 1332(c)–3 of this title.

**Effective Date of 1984 Amendment**

Section 2301(c)(1) of Pub. L. 98–369 provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to items and services furnished on or after January 1, 1985." Amendment by section 2304(c) of Pub. L. 98–369 applicable to pacemaker devices and leads implanted or removed on or after the effective date of final regulations promulgated to carry out such amendment, see section 2304(d) of Pub. L. 98–369, set out as a note below.

Section 2313(e) of Pub. L. 98–369 provided that: "The amendments made by this section [amending this section and section 1395w of this title] shall be effective on the date of the enactment of this Act [July 18, 1984]."

Section 2344(d) of Pub. L. 98–369 provided that: "The amendments made by this section [amending this section and sections 1320c–6 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]."

Amendment by section 2354(b)(30), (31) 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.

**Effective Date of 1983 Amendments**

Amendment by section 601(f) of 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, and amendment by section 602(e)(3) of Pub. L. 98–21 effective Oct. 1, 1983, see section 604(a)(1), (2) of Pub. L. 98–21, set out as a note under section 1385ww of this title.

Amendment by Pub. L. 97–248 effective as if originally included as a part of this section as was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–248, set out as a note under section 1362–1 of this title.

**Effective Date of 1982 Amendment**

Amendment by section 116(b) of Pub. L. 97–248 applicable with respect to items and services furnished on or after Jan. 1, 1983, see section 116(c) of Pub. L. 97–248, set out as a note under section 623 of Title 29, Labor.

Amendment by section 9343(c)(1) of Pub. L. 99–509 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 1395cc of this title.

Amendment by section 129(c)(2)–(4) of Pub. L. 98–21 applicable as if originally included as part of this section as was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 1320a–1 of this title.

Section 128(c)(3) of Pub. L. 98–369 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

**Effective Date of 1981 Amendment**

Section 2108(a)(2) of Pub. L. 97–35 provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to expenses incurred on or after October 1, 1981."

Section 2108(c)(1) of Pub. L. 97–35 provided that: "The amendments made by subsection (a) [amending this section] shall become effective on October 1, 1981."

**Effective Date of 1980 Amendments**

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395i of this title.

Amendment by section 936(c) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Amendment by section 939(b) of Pub. L. 96–499 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to services furnished on or after July 1, 1981."

**Effective Date of 1977 Amendments**

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1385k of this title.

Amendment by section 13(c) of Pub. L. 95–142 provided that: "The amendments made by this section [amending this section and sections 1320c–6 and 1395cc of this title] shall apply to items and services furnished on or after the date of enactment of this Act [July 18, 1984]."

Amendment by section 2334(a) 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 2334(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.
take effect on the date of the enactment of this Act [Oct. 25, 1977].”

**Effective Dates of 1973 Amendment**

Amendment by Pub. L. 93–233 effective with respect to admissions subject to the provisions of section 1395(a)(2) of this title which occur after Dec. 31, 1973, see section 182–3(d)(2) of Pub. L. 93–233, set out as a note under section 1395f of this title.

Amendment by section 211(c)(1) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 256(c) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

**Effective Date of 1968 Amendment**

Amendment by section 127(b) of Pub. L. 90–248 applicable with respect to services furnished after Dec. 31, 1967, see section 127(c) of Pub. L. 90–248, set out as a note under section 1395x of this title.

**Notification to Physicians of Excessive Home Health Visits**

Section 614(a)(1) of Pub. L. 105–33 provided that: “The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health visits, furnished under title XVIII of the Social Security Act [this subchapter] pursuant to a prescription or certification of the physician, significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.”

**Distribution of Questionnaire by Contractor**

Section 151(a)(1)(B) of Pub. L. 103–432 provided that: “The Secretary of Health and Human Services shall enter into an agreement with an entity not later than 60 days after the date of the enactment of the Social Security Amendments of 1994 [Oct. 31, 1994], to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act [subsec. (b)(5)(D) of this section] (as added by subparagraph (A)).

**Retroactive Exemption for Certain Situations Involving Religious Orders**

Section 13561(f) of Pub. L. 103–66 provided that: “Section 1862(b)(1)(D) of the Social Security Act [subsec. (b)(1)(D) of this section] applies, with respect to items and services furnished before October 1, 1989, to any plans performed will be considered to meet the requirements of section 1862(a)(1)(A) of the Social Security Act (as added by subparagraph (A)), effective with respect to admittance on the date of the enactment of this Act.

**GAO Study of Extension of Secondary Payer Period**

Section 4203(c)(2) of Pub. L. 101–508, as amended by Pub. L. 103–432, title I, §151(c)(7), Oct. 31, 1994, 108 Stat. 436, provided that: “(A) The Comptroller General shall conduct a study of the impact of the second sentence of section 1862(b)(1)(C) of the Social Security Act [subsec. (b)(1)(C) of this section], and shall include in such report information relating to—

(ii) the number (and geographic distribution) of such individuals for whom medicare is secondary; and

(iii) the effect on access to employment, and employment-based health insurance, for such individuals and their family members (including coverage by employment-based health insurance of cost-sharing requirements under medicare after such employment-based insurance becomes secondary);

(iv) the effect on the amount paid for each dialysis treatment under employment-based health insurance;

(v) the effect on cost-sharing requirements under employment-based health insurance (and on out-of-pocket expenses of such individuals) during the period for which medicare is secondary; and

(vi) the appropriateness of applying the provisions of section 1862(b)(1)(C) of such Act [subsec. (b)(1)(C) of this section] to all group health plans, without regard to the number of employees covered by such plans.

(B) The Comptroller General shall submit a preliminary report on the study conducted under subparagraph (A) to the Committees on Ways and Means and Energy and Commerce [Committee on Energy and Commerce now Committee on Commerce] of the House of Representatives and the Committee on Finance of the Senate not later than January 1, 1993, and a final report on such study not later than January 1, 1995.

[Section 151(c)(7) of Pub. L. 103–432 provided that the amendment made by that section to section 4203(c)(2) of Pub. L. 101–508, set out above, is effective as if included in the enactment of Pub. L. 101–508.]

**Deadline for First Transmittal and Request of Matching Information**

Section 6202(a)(2) of Pub. L. 101–239 provided that: “The Commissioner of Social Security shall first—

(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act [subsec. (b)(5)(A)(i) of this section] (as inserted by subparagraph (A)), and

(ii) request from the Secretary disclosure of information described in section 6013(h)(12)(A) of the Internal Revenue Code of 1986 [26 U.S.C. 6013(h)(12)(A)], by not later than 14 days after the date of the enactment of this Act [Dec. 19, 1988].

**Designation of Pediatric Hospitals as Meeting Certification as Heart Transplant Facility**

Section 4009(b) of Pub. L. 100–203 provided that: “For purposes of determining whether a pediatric hospital that performs pediatric heart transplants meets the criteria established by the Secretary of Health and Human Services for facilities in which the heart transplants performed will be considered to meet the requirements of section 1862(a)(1)(A) of the Social Security Act [subsec. (a)(1)(A) of this section], the Secretary shall treat such a hospital as meeting such criteria if—

(1) the hospital’s pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria.

(2) the unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria), and

(3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.”

**Approval of Surplus Applicants for Procedures Performed April 1, 1986, to December 15, 1986**

Section 1895(b)(16)(C) of Pub. L. 99–514 provided that: “For purposes of section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)), added by section 9076(a)(3) of COBRA, and for surgical procedures performed during the period beginning on April 1, 1986, and ending on December 15, 1986, a carrier is deemed to have approved the use of an assistant in a surgical procedure, before the surgery is performed, based on the existence of a complicating medical condition if the carrier determines after the surgery is performed that the use of the assistant in the procedure was appro-
private based on the existence of a complicating medical condition before or during the surgery."

EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS


“(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act [subsec. (a)(1)(C) of this section], apply (under section 1679(a) of such Act [section 1395p(a) of this title]) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

“(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act [Oct. 21, 1986] and before December 31, 1995.”

Section 4008(a)(3) of Pub. L. 101–508 provided that:

“The amendments made by paragraphs (1) and (2) [amending section 9305(f) of Pub. 99–509, set out above, and section 9126(c) of Pub. L. 99–272, set out below] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].”

STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY OF AMENDMENTS RELATING TO LARGE GROUP HEALTH PLANS AND MEDICARE AS SECONDARY PAYERS

Section 9313(e) of Pub. L. 99–509 directed Comptroller General to study and report to Congress, not later than Mar. 1, 1990, the impact of the amendments made by this section (enacting section 5000 of Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395f of this title) on access of disabled individuals and members of their family to employment and health insurance, such report to include information relating to number of disabled Medicare beneficiaries for whom Medicare has become secondary, either through their employment or the employment of a family member, amount of savings to the Medicare program achieved annually through this provision, and effect on employment, and employment-based health coverage, of disabled individuals and family members.

RESTATEMENT OF WAIVER OF LIABILITY PRESUMPTION

Section 9126(c) of Pub. L. 99–272, as amended by Pub. L. 100–360, title IV, §426(b), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, §4008(a)(1), Nov. 5, 1990, 104 Stat. 1388–44, provided that: “The Secretary of Health and Human Services shall, for purposes of determining whether payments to a skilled nursing facility should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [subsec. (a)(1)(A) of this section], apply the same presumption of compliance (5 percent) as in effect under regulations as of July 1, 1985. Such presumption shall apply for the period beginning after the first month beginning after the date of the enactment of this Act [Apr. 7, 1986] and ending on December 31, 1995.”

HOME HEALTH WAIVER OF LIABILITY

Section 2005 of Pub. L. 99–272, as amended by Pub. L. 100–360, title IV, §426(d), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title I, §1358(b)(1), Oct. 31, 1991, 105 Stat. 1442, provided that: “The Secretary of Health and Human Services shall, for purposes of determining whether payments to a home health agency should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [subsec. (a)(1)(A) of this section], apply a presumption of compliance (2.5 percent) in the same manner as under the regulations in effect as of July 1, 1985. Such presumption shall apply until December 31, 1995.”


RECOMMENDATIONS AND GUIDELINES FOR ELIMINATION OF ASSISTANTS AT SURGERY: REPORT TO CONGRESS

Section 9307(d) of Pub. L. 99–272 provided that the Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, develop recommendations and guidelines respecting other surgical procedures for which an assistant at surgery was generally not medically necessary and circumstances under which use of an assistant at surgery was generally appropriate but should be subject to prior approval of an appropriate entity and that the Secretary report to Congress, not later than January 1, 1987, on these recommendations and guidelines.

PACKEMAKER REIMBURSEMENT REVIEW AND REFORM; PROMULGATION OF REGULATIONS: EFFECTIVE DATE OF PACEMAKER REGISTRATION

Section 2304(d) of Pub. L. 98–369 provided that: “The Secretary of Health and Human Services shall promulgate final regulations to carry out this section and the amendment made by this section [amending section 1395 of this title and enacting provisions set out as a note under section 1395f of this title prior to January 1, 1985, and the amendment made by subsection (c) of this section] shall apply to pacemaker devices and leads implanted or removed on or after the effective date of such regulations.”

PAYMENT FOR DERIVEMENT OF MYCOTIC TOENAILS

Section 3235 of Pub. L. 98–369 provided that: “The Secretary shall provide, pursuant to section 1862(a) of the Social Security Act [subsec. (a) of this section], that payment will not be made under part B of title XVII of such Act [part B of this subchapter] for a physician’s derivement of mycotic toenails to the extent such derivement is performed for a patient more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing physician.”

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS’ SERVICES

Section 602(k) of Pub. L. 98–21, as amended by Pub. L. 99–272, title IX, §9112(a)(1), Apr. 7, 1986, 100 Stat. 163, provided that:

“(1) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act [subsec. (a)(14) of this section and section 1395ccc(a)(1)(H) of this title] in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XV of such Act [part B of this subchapter] for services (other than physicians’ services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title [part A of this subchapter] shall be reduced by the amount of the billings for such services under part B of such title.

If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

“(2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part B of title XVII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver.”
"(3) Any waiver granted under paragraph (1) shall provide that, with respect to those items and services billed under part B of title XVIII of the Social Security Act, on the reasons for which such waiver—

"(A) payment under such part shall be equal to 100 percent of the reasonable charge or other applicable payment base for the items and services; and

"(B) the entity furnishing the items and services must agree to accept the amount paid pursuant to subparagraph (A) as the full charge for the items and services.

[Section 9112(b) of Pub. L. 99–272 provided that:

"(1) Section 602(k)(2) of the Social Security Amendments of 1963 (as added by subsection (a)) [set out above] shall apply to cost reporting periods beginning on or after January 1, 1986.

"(2) Section 602(k)(2) of the Social Security Amendments of 1983 (as added by subsection (a) [set out above] shall apply to items and services furnished after the end of the 10-day period beginning on the date of the enactment of this Act [Apr. 7, 1986].]

PROHIBITION OF PAYMENT FOR INEFFECTIVE DRUGS

Section 115(b) of Pub. L. 97–248 provided that: "No provision of law limiting the use of funds for purposes of enforcing or implementing section 1862(c) [subsec. (c) of this section] or section 1903(i)(5) [section 1396b(i)(5) of this title] of the Social Security Act, section 2103 of the Omnibus Budget Reconciliation Act of 1981 [section 2103 of Pub. L. 97–35, amending sections 1935y and 1936b of this title and enacting provisions set out as notes under sections 1985y and 1986b of this title], or any rule or regulation issued pursuant to any such section (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations) shall apply to any period after September 30, 1982, unless such provision of law is enacted after the date of the enactment of this Act (Sept. 3, 1982) and specifically states that such provisions override this section.

ESTABLISHMENT AND IMPLEMENTATION OF GUIDELINES

Section 2152(b) of Pub. L. 97–35 directed the Secretary of Health and Human Services to establish and provide for the implementation of, the guidelines described in subsec. (f) of this section not later than Oct. 1, 1981.

REPORT TO CONGRESSIONAL COMMITTEES ON IMPLEMENTATION OF CERTIFICATION REQUIREMENTS RELATING TO MODIFICATION OF HEALTH BENEFITS PLAN OR PROGRAM; FAILURE TO SUMMIT REPORT

Section 4(b) of Pub. L. 93–480 provided that the Civil Service Commission and the Secretary of Health, Education, and Welfare submit a report on or before Mar. 1, 1975, on the steps which have been taken, and the steps which are planned, to enable the Secretary to make the determination and certification referred to in former subsec. (c) of this section and that, if such report is not submitted by Mar. 1, 1975, the date specified in former subsec. (c) shall be deemed to be July 1, 1975, rather than Jan. 1, 1976.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1320a–7a, 1320c, 1320c–3, 1320c–7, 1320c–8, 1320h, 1320i, 1320j, 1320k, 1320l, 1320m, 1320n, 1320p, 1320q, 1320r, 1320s, 1320t, 1320u, 1320v, 1320w, 1320x, 1320y, 1320z, 1320z–1, 1320z–2, 1320z–3, 1320z–4, 1320z–5, 1320z–6, 1320z–7, 1320z–8, 1320z–9, 1320z–10, 1320z–11, 1320z–12, 1320z–13, 1320z–14, 1320z–15, 1320z–16, and 1320z–17 of this title; title 10 sections 1095; title 26 sections 5000, 6103; title 45 section 231f.

§ 1395x. Consultation with State agencies and other organizations to develop conditions of participation for providers of services

In carrying out his functions, relating to the determination of conditions of participation by providers of services, under subsections (e)(4), (f)(4), (j)(15), 1 (o)(6), (cc)(2)(I), and 2 (dd)(2), and

1 See References in Text note below.

2 So in original. The word "and" probably should not appear.
Amendment by Pub. L. 96–499 applicable to screening mammography performed on or after Jan. 1, 1991, see section 2335(e)(1) of Pub. L. 98–369, set out as a note under section 1395x of this title.

Effective Date of 1994 Amendment

Amendment by Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 235b(b) of this title apply to such mammography conducted by such facility, see section 235b(d)(1) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Effective Date of 1990 Amendment

Amendment by Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 235d(c) of Pub. L. 101–508, set out as a note under section 1320a of this title.

Effective Date of 1989 Amendment


Effective Date of 1988 Amendment

Amendment by section 233(c)(2) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 233(g) of Pub. L. 100–360, set out as a note under section 1320a–3 of this title.

Amendment by section 234(c)(1) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 234(e) of Pub. L. 100–360, set out as a note under section 1320a–7m of this title.

Effective Date of 1984 Amendment

Amendment by section 233(c) of Pub. L. 98–369 effective July 18, 1984, see section 233(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 234(b)(1) of Pub. L. 98–369 effective July 18, 1984, see section 234(c) of Pub. L. 98–369, set out as a note under section 1320a–7a of this title.

Amendment by section 234(b)(2) 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 234(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Effective Date of 1982 Amendment

Amendment by 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 1980 Amendment

Amendment by section 933(c) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

Effective Date of 1972 Amendment

Amendment by Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after the 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.

Termination of Advisory Councils

Advisory councils in existence on Jan. 5, 1973, to terminate not later than the expiration of the 2-year period following Jan. 5, 1973, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law. See sections 3(2) and 14 of Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, 776, set out in the Appendix to Title 5, Government Organization and Employees.

Section Referred to in Other Sections

This section is referred to in in section 1395bb of this title; title 45 section 231f.

§1395aa. Agreements with States

(a) Use of State agencies to determine compliance by providers of services with conditions of participation

The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or whether a facility therein is a rural health clinic as defined in section 1395x(aa)(2) of this title, a critical access hospital, as defined in section 1395x(mm)(1) of this title, or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title, or whether a laboratory meets the requirements of paragraphs (16) and (17) of section 1395x(s) of this title, or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1395x(p)(4) of this title, or whether an ambulatory surgical center meets the standards specified under section 1395k(a)(2)(F)(i) of this title. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1395x of this title) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1395l–3(a) of this title. Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' re-
representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinical agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1395bb of this title, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

(b) Payment in advance or by way of reimbursement to State for performance of functions of subsection (a)

The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make such payments in account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a) of this section, and for the Federal Hospital Insurance Trust Fund’s fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A of this subchapter, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) Use of State or local agencies to survey hospitals

The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) of this section will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), provider entities that, pursuant to subsection (a) or (b)(1) of section 1395bb of this title, are treated as meeting the conditions or requirements of this subchapter. The Secretary shall pay for such services in the manner prescribed in subsection (b) of this section.

(d) Fulfillment of requirements by States

The Secretary may not enter into an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1395i–3(e) of this title and section 1395i–3(g) of this title and the establishment of remedies under sections 1395i–3(b)(2)(B) and 1395i–3(c) of this title (relating to establishment and application of remedies).

(e) Prohibition of user fees for survey and certification

Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a) of this section, or any renal dialysis facility subject to the requirements of section 1395rr(b)(1) of this title, for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this subchapter (other than any fee relating to section 263a of this title).

Part A of this subchapter, referred to in subsec. (b), is classified to section 1395c et seq. of this title.

AMENDMENTS

1997—Subsec. (a). Pub. L. 105–33, § 4201(c)(1), substituted “critical access” for “rural primary care”.

Pub. L. 105–33, § 4106(c), substituted “(16) and (17)” for “(15) and (16)”.

1996—Subsec. (c). Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 103–203, § 4212(b), which directed an amendment of subsec. (a) identical to Pub. L. 100–203, § 4022(c), inserted “or whether screening mammography meets the standards established under section 1395m(c)(3) of this title” after “section 1395x(s) of this title or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title”.

Subsec. (e). Pub. L. 103–432, § 160(a)(1)(A), inserted before period at end “(other than any fee relating to section 263a of this title)”.

1990—Subsec. (a). Pub. L. 101–508, § 4163(c)(2), inserted before period at end of first sentence “, or whether screening mammography meets the standards established under section 1395m(c)(3) of this title”.

Subsec. (e). Pub. L. 103–432, § 160(a)(1)(A), inserted before period at end of first sentence “, or whether screening mammography meets the standards established under section 1395m(c)(3) of this title”.

Subsec. (a). Pub. L. 101–508, § 4163(c)(2), inserted before period at end of first sentence “, or whether screening mammography meets the standards established under section 1395m(c)(3) of this title or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title”.

Subsec. (e). Pub. L. 103–432, § 160(a)(1)(A), inserted before period at end of first sentence “, or whether screening mammography meets the standards established under section 1395m(c)(3) of this title or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title”.


1989—Subsec. (a). Pub. L. 101–239, § 6115(c), inserted “paragraphs (15) and (16)” for “paragraphs (14) and (15)”.

Subsec. (e). Pub. L. 101–239, § 6003(g)(3)(C)(iii), inserted “, a rural primary care hospital, as defined in section 1395a(mm)(1) of this title, after “1395a(aa)(2) of this title”.

Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, § 204(c)(3), 204(c)(2), 204(c)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 and 1989 Amendment notes.


Subsec. (a). Pub. L. 100–360, § 411(d)(4)(A)(ii), as added by Pub. L. 100–485, § 608(d)(20)(B)(ii), substituted “most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency,” for “most recent certification survey conducted with respect to the home health agency,” after “section 1395x(g) of this title”, for “section 1395x(s) of this title.”

Subsec. (a). Pub. L. 100–360, § 411(d)(4)(A)(ii), as added by Pub. L. 100–485, § 608(d)(20)(C), substituted “such State or local agency to maintain a unit” for “his or her legal representative.”

Subsec. (a). Pub. L. 100–360, § 411(d)(4)(A)(iv), as added by Pub. L. 100–485, § 608(d)(20)(B), substituted “utilized by the Secretary under section 1395bb of this title” for “pursuant to an agreement with the Secretary under this section”. Pub. L. 100–360, § 204(c)(2), inserted “, or whether screening mammography meets the standards established under section 1395m(c)(3) of this title” after “section 1395k(a)(2)(F)(i) of this title”.

Subsec. (a). Pub. L. 100–360, § 203(e)(3), inserted “or a home intravenous drug therapy provider,” after “hospice program” and substituted “hospice program, or home intravenous drug therapy provider” for “or hospice program”.

1987—Subsec. (a). Pub. L. 100–203, § 4212(b), which directed an amendment of subsec. (a) identical to Pub. L. 100–203, § 4202(c), was amended generally by Pub. L. 100–360, § 411(h)(6)(B), so that it does not amend this section but rather section 1396b of this title.

Subsec. (a). Pub. L. 100–203, § 4202(c), inserted “, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients and patients’ representatives,” after “place” in fifth sentence.

Subsec. (a). Pub. L. 100–203, § 4203(d)(4), as added by Pub. L. 100–360, § 411(k)(1)(C), as added by Pub. L. 100–485, § 608(d)(27)(B), substituted “conditions specified in section 13861–3(a) of this title” for “conditions specified in section 1395x(j) of this title.”

Subsec. (a). Pub. L. 100–203, § 4072(d), substituted paragraphs (13) and (14) for paragraphs (12 and 15) in first sentence.

Subsec. (a). Pub. L. 100–203, § 4025(a), inserted at end “Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted with respect to the agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency pursuant to an agreement with the Secretary under this section, and consumer medical records (but only with the consent of the consumer or his or her legal representative).”

Subsec. (d). Pub. L. 100–203, § 4203(a)(1), inserted before period at end “and the establishment of remedies under sections 1395l–3(b)(2)(B) and 1395l–3(b)(2)(C) of this title (relating to establishment and application of remedies).”

Subsec. (a). Pub. L. 99–509 added “paragraphs (12) and (13)” for “paragraphs (11) and (12)”.

1986—Subsec. (a). Pub. L. 99–509 stricken out “the” after “Joint Commission on”. This section was enacted as Pub. L. 100–203, § 4201(d)(4), which did not amend this section.


1984—Subsec. (c). Pub. L. 98–389 inserted a period at end “and section 1395l–3(g) of this title” before period at end.


1982—Subsec. (a). Pub. L. 97–248 inserted “or whether an agency is a hospice program and substituted “home health agency, or hospice program” for “or home health agency”.

1980—Subsec. (a). Pub. L. 96–611 substituted “requirements of paragraphs (11) and (12) of section 1395x(s) of this title” for “requirements of paragraphs (10) and (11) of section 1395x(s) of this title”.

1975—Pub. L. 94–409, § 933(g), inserted “or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title” and “comprehensive outpatient rehabilitation facility,” after “rural health clinic in four places.”
Pub. L. 96–499, §934(c)(2), inserted “, or whether an ambulatory surgical center meets the standards specified under section 1385(a)(2)(F) of this title” after “‘ambulatory surgical center,’” after “health care facility,” in three places.

1977—Subsec. (a). Pub. L. 95–210 expanded enumeration of institutions and agencies included under coverage of this subsection by inserting references to rural health clinics in five places.

1972—Subsec. (a). Pub. L. 92–603, §§277, 278(a)(18), (b)(15), 299D(a), provided for the furnishing of specialized consultative services to skilled nursing facilities, authorized the Secretary to make public the pertinent findings of each survey within 90 days following the completion of each survey of any health care facility “extended care facility”.

Subsec. (c). Pub. L. 92–603, §244(a), added subsec. (c).

1968—Subsec. (a). Pub. L. 90–248, §138(f), inserted clause at end of first sentence determining whether a clinic, rehabilitation agency, or public health agency meets the requirements of section 1395k(p)(14)(A) or (B) of this title.

Pub. L. 90–248, §228(b), struck out last sentence providing for utilization of State facilities to provide consultative services to institutions furnishing medical care, covered in section 1396a(a)(24) of this title.

Effective Date of 1997 Amendment
Amendment by section 4106(c) of Pub. L. 105–33 applicable to screening mammography performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Amendment by section 4201(a)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Effective Date of 1994 Amendment
Amendment by section 145(c)(3) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395x of this title.

Effective Date of 1990 Amendment
Section 4154(d)(2) of Pub. L. 101–508 provided that: “The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988 [Pub. L. 100–578].” Amendment by section 4163(c)(2) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395x of this title.

Effective Date of 1989 Amendments
Amendment by section 615(c) of Pub. L. 101–238 applicable to screening pap smears performed on or after July 1, 1990, see section 615(d) of Pub. L. 101–238, set out as a note under section 1395x of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Effective Date of 1988 Amendments
Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 203(e)(3) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(c)(2), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395x of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(A), (1)(C), (6)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title I, General Provisions.

Effective Date of 1987 Amendment
Section 4025(c), formerly §4025(b), of Pub. L. 100–203, as redesignated and amended by Pub. L. 100–360, title IV, §411(d)(4)(B)(1), July 1, 1988, 102 Stat. 774, provided that: “The amendment made by this section [amending this section and section 1395bb of this title] shall apply with respect to agreements entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987].” For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendments by sections 4201(a)(2), (d)(4) and 4202(a)(1), (c) of Pub. L. 100–233 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

Amendment by section 4203(a)(1) of Pub. L. 100–203 applicable Jan. 1, 1998, except as otherwise specifically provided in section 1395i–3 of this title, without regard to whether regulations to implement such amendment are promulgated by such date, and in applying amendment by section 4203(a)(2) of Pub. L. 100–203 for services furnished by a skilled nursing facility before Oct. 1, 1990, any reference to a requirement of section 1395i–3(b), (c), or (d) of this title is deemed a reference to section 1395x(j) of this title, see section 4204(b) of Pub. L. 100–203, as added by Pub. L. 100–485, set out as an Effective Date note under section 1395i–3 of this title.

Effective Date of 1986 Amendment
Amendment by Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9230(b)(1), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Effective Date of 1984 Amendment
Amendment by 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(c)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Effective Date of 1982 Amendment
Amendment by 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 1396c of this title.

Effective Date of 1980 Amendments
Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395j of this title.

For effective date of amendment by section 933(g) of Pub. L. 96–499, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

Effective Date of 1977 Amendment
Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month
which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

**Effective Date of 1972 Amendment**

Section 299D(c) of Pub. L. 92–603 provided that: “The provisions of this section [amending this section and section 1396a of this title] shall be effective beginning January 1, 1973, or within 6 months following the enactment of this Act [Oct. 30, 1972], whichever is later.”

**Effective Date of 1968 Amendment**

Amendment by section 133(i) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Section 228(b) of Pub. L. 90–248 provided that the amendment made by such section 228(b) is effective July 1, 1969.

**Use of State or Local Agencies in Evaluating Laboratories**

Section 168(a)(2) of Pub. L. 98–423 provided that: “An agreement made by the Secretary of Health and Human Services with a State under section 1864(a) of the Social Security Act [subsec. (a) of this section] may include an agreement that the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary for the purpose of determining whether a laboratory meets the requirements of section 353 of the Public Health Service Act [section 263a of this title].”

**Nurse Aid Training and Competency Evaluation, Failure by State to Meet Guidelines**

Section 4008(b)(1)(A) of Pub. L. 101–508 provided that: “The Secretary of Health and Human Services may not refuse to enter into an agreement or cancel an existing agreement with a State under section 1864 of the Social Security Act (this section) on the basis that the State failed to meet the requirement of section 1819(e)(1)(A) of such Act [section 1395i–3(e)(1)(A) of this title] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1819(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.”

*Section Referred to in Other Sections* This section is referred to in sections 263a–2, 1320a–7a, 1320a–7e, 1320a–7h, 1395f, 1395bb, 1395x, 1395bbb, 1396a of this title; title 45 section 231f.

### § 1395bb. Effect of accreditation

#### (a) In general

Except as provided in subsection (b) of this section and the second sentence of section 1395z of this title, if—

1. An institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

2. (A) such institution authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),

3. such Commission releases such a copy and any such information to the Secretary, then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1395x(e) of this title; except—

3. (C) paragraph (6) thereof, and

4. any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1395x(e)(6) of this title or the standard described in such paragraph (4), as the case may be.

(b) Accreditation by American Osteopathic Association or other national accreditation body

(1) In addition, if the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or requirements of this subchapter (other than the requirements of section 1395m(j) of this title or the conditions and requirements under section 1395m(r)(b) of this title) are met or exceeded:

(A) in the case of a provider entity not described in paragraph (3)(B), the Secretary shall treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or

(B) in the case of a provider entity described in paragraph (3)(B), the Secretary may treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

(2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

(3) (A) Except as provided in subparagraph (B), not later than 60 days after the date of receipt of a written request for a finding under paragraph (1) (with any documentation necessary to make a determination on the request), the Secretary shall publish a notice identifying the national accreditation body making the request, describing the nature of the request, and providing a period of at least 30 days for the public to comment on the request. The Secretary shall approve or deny a request for such a finding, and shall publish notice of such approval or denial,
not later than 210 days after the date of receipt of the request (with such documentation). Such an approval shall be effective with respect to accreditation determinations made on or after such effective date (which may not be later than the date of publication of the approval) as the Secretary specifies in the publication notice.

(b) The 210-day and 60-day deadlines specified in subparagraph (A) shall not apply in the case of any request for a finding with respect to accreditation of a provider entity to which the conditions and requirements of section 1395l–3 and 1395x(j) of this title apply.

(4) For purposes of this section, the term “provider entity” means a provider of services, supplier, facility, clinic, agency, or laboratory.

(c) Disclosure of accreditation survey

The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to him by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association survey, or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(d) Deficiencies

Notwithstanding any other provision of this subchapter, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall, after the date of notice of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements of this section, see section 1395aa(c) of this title.


References in Text

Subsection (b) of this section, referred to in subsec. (a), was redesignated subsec. (d) and a new subsec. (b) added by Pub. L. 104–134, title I, § 101(d) [title V, § 516(b)(1), (3)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–246; renumbered title I, Pub. L. 104–140, § 1(a), May 2, 1996, 110 Stat. 1327.

Amendments

1996—Subsec. (a). Pub. L. 104–134, § 101(d) [title V, § 516(b)(2), (3)], struck out after second sentence: “In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1395x(a)(2)(F)(i), 1395x(e), 1395x(f), 1395x(j), 1395x(o), 1395x(p)(4)(A) or (B), paragraphs (15) and (16) of section 1395x(e), section 1395aa(a)(2), 1395cc(2), 1395dd(2), or 1395x(mm)(1) of this title, as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding:” and redesignated fourth sentence as subsec. (c).


Subsec. (c). Pub. L. 104–134, § 101(d) [title V, § 516(b)(2)], redesignated fourth sentence of subsec. (a) as subsec. (c).

Subsec. (d). Pub. L. 104–134, § 101(d) [title V, § 516(b)(1), (c)(2)(A)], redesignated subsec. (b) as (d) and substituted “a provider entity” for “a hospital”, “the entity” for “the hospital” in two places, and “the conditions or requirements the entity has been treated as meeting pursuant to subsection (a) or (b)(1) of this section” for “the requirements of the numbered paragraphs of section 1395x(e) of this title”.


1989—Subsec. (a). Pub. L. 101–239, § 6115(c), substituted “paragraphs (15) and (16)” for “paragraphs (14) and (15)”.

Pub. L. 101–239, § 6019(b), inserted before period at end “except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary”.

Pub. L. 101–239, § 6003(c)(3), substituted “1395dd(2), or 1395x(mm)(1) of this title” for “or 1395x(dd)(2) of this title” in third sentence.

Pub. L. 101–234 repealed Pub. L. 100–360, § 204(c)(3), (d)(3), 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 and 1989 Amendment notes.

1988—Subsec. (a)(2). Pub. L. 101–239, § 6010(a), designated existing provisions as subpar. (A), struck out “if it is included within a survey described in section 1395aa(c) of this title” after “such institution”, inserted “... together with any other information directly related to the survey as the Secretary may require (including corrective action plans)” after “by such Commission”, and added subpar. (B).

Subsec. (b). Pub. L. 101–239, § 6010(c), struck out “following a survey made pursuant to section 1395aa(c) of this title” after “if the Secretary finds”.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

**Effective Date of 1988 Amendments**

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–360, set out as a note under section 704 of this title.

Amendment by section 294(c)(3), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 201(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(B)(ii) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

**Effective Date of 1987 Amendment**

Amendment by section 4025(b) of Pub. L. 100–203 applicable with respect to agreements entered into or renewed on or after Dec. 22, 1987, see section 4025(c) of Pub. L. 100–203, as amended, set out as a note under section 1395aa of this title.

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

**Effective Date of 1986 Amendment**

Amendment by section 9305(c)(3) of Pub. L. 99–509 applicable to hospitals as of one year after Oct. 21, 1986, see section 9305(c)(4) of Pub. L. 99–509, set out as a note under section 1395x of this title.

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395x of this title.

**Effective Date of 1984 Amendment**

Section 2345(b) of Pub. L. 98–369 provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984], and shall apply with respect to surveys released to the Secretary on, before, or after such date."

Section 234(b) of Pub. L. 98–369 provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

**Effective Date of 1982 Amendment**

Amendment by section 122(g)(4) 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 1395d of this title.

Amendment by section 122(b)(4) of Pub. L. 97–248 applicable to screening mammography performed on or after Jan. 1, 1990, see section 1395f(b)(4) of Pub. L. 97–248, set out as a note under section 1395f of this title.

**Effective Date of 1980 Amendments**

Section 601(d) of Pub. L. 101–199 provided that: "If Except as provided in paragraph (2), the amendments made by this section [amending this section shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

"The amendments made by subsection (a) [amending this section] shall take effect 6 months after the date of the enactment of this Act."

Amendment by section 611(c) of Pub. L. 101–239 applicable to screening mammography performed on or after July 1, 1990, see section 1115(d) of Pub. L. 101–239, set out as a note under section 1395f of this title.

**Effective Date of 1972 Amendment**

Amendment by section 234(h) of Pub. L. 98–603 applicable with respect to providers of services for fiscal years beginning after the fifth month following October 1972, see section 234(i) of Pub. L. 98–603, set out as a note under section 1395x of this title.

**Section Referred to in Other Sections**

This section is referred to in sections 1320c–9, 1395w–22, 1395x, 1395aa of this title.
§ 1395cc. Agreements with providers of services
(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395(e) of this title), and

(ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title.

(B) to not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI of this chapter as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F) (i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A of this subchapter, and (II) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews,

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A), and

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A of this subchapter but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H) (i) in the case of hospitals which provide services for which payment may be made under this subchapter and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that...
are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395w(y)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

(II) for which the individual is entitled to have payment made under this subchapter, to have items and services (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by the skilled nursing facility otherwise under arrangements (as defined in section 1395w(y)(1) of this title) made by the skilled nursing facility,

(I) in the case of a hospital or critical access hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 1713 of title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10,

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under section 1703 of title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A of this subchapter (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicare program under a State plan approved under subchapter XIX of this chapter,

(O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare-Choice organization under part C of this subchapter or with an eligible organization (i) with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b–1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter
who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services.

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) of this section (relating to maintaining written policies and procedures respecting advance directives).

(R) to contract only with a health care clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI of this chapter on or after the date on which the health care clearinghouse is required to comply with the standard or specification, and

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(Ii) of this title, or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (P), which organization's contract with the Secretary under part B of subchapter XI of this chapter is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction imposed under section 1395f(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B of this subchapter under the prospective payment system established under section 1395f(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395f(t)(5) of this title.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished to an individual or other person with respect to which a satisfactory is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or

1 See References in Text note below.
equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual with respect to which a deduction is imposed under section 1395cc(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c–3(a)(4)(A) of this title and under section 1320c–3(a)(14) of this title with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(1) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(2) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of subchapter XI of this chapter.

(b) Termination or nonrenewal of agreements

(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title;

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title;

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a–7 of this title or section 1320a–7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a–7(c) of this title.

(c) Refiling after termination or nonrenewal; agreements with skilled nursing facilities

(1) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under subchapter XIX of this chapter of such termination or nonrenewal.

(d) Decision to withhold payment for failure to review long-stay cases

If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(k) of this title of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been
removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) "Provider of services" defined

For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of section 1395x(y) of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of section 1395x(y) of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1395x(y) of this title) with respect to the furnishing of outpatient occupational therapy services; and

(2) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(f)(1) of this title).

(f) Maintenance of written policies and procedures

(1) For purposes of subsection (a)(1)(Q) of this section and sections 1385l–3(c)(2)(E), 1395b, 1395w–25(l), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual’s current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual’s admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual’s admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395(a)(1)(A) of this title or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Penalties for improper billing

Except as permitted under subsection (a)(2) of this section, any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) of this section or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(f) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.
Title 42—The Public Health and Welfare

**Interim Sanctions for Psychiatric Hospitals**

1. If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this subchapter and further finds that the hospital's deficiencies—

   (A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

   (B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the effective date of the finding, or both.

2. If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this subchapter—

   (A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the end of such 3-month period, or

   (B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this subchapter with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this subchapter.

References in Text

Parts A and B of this subchapter, referred to in subsec. (a), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

Part B of subchapter XI of this chapter, referred to in subsec. (a)(1)(O), is classified to section 1395w-21 et seq. of this title.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(O)(i), is section 222(a) of Pub. L. 96-263, which is set out as a note under section 1395w-21 of this title.

Part C of subchapter XI of this chapter, referred to in subsec. (a)(1)(R), is classified to section 1395w-21 et seq. of this title.


Amendments

§ 1395cc


1997—Subsec. (a)(1)(A). Pub. L. 105–33, § 4714(b)(1), redesignated former cls. (i) and inserted before comma at end ‘‘, and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title’’. Pub. L. 105–33, § 4332(b)(5)(F), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subs. (I) and (II), respectively, and added cls. (III).

Subsec. (a)(1)(B). Pub. L. 105–33, § 4511(a)(2)(D), substituted ‘‘section 1395x(s)(2)(K)(iii) of this title’’ for ‘‘section 1395x(s)(2)(K) of this title’’.

Subsec. (a)(1)(C). Pub. L. 105–33, § 432(b)(5), substituted ‘‘critical access’’ for ‘‘rural primary care’’.


Subsec. (a)(1)(H). Pub. L. 105–33, § 4008(m)(3)(G) [(F)], substituted ‘‘section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title’’ for ‘‘section 1395x(s)(2)(K) of this title’’.

Subsec. (a)(1)(I). Pub. L. 105–33, § 4008(m)(3)(G) [(F)], substituted ‘‘section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title’’ for ‘‘section 1395x(s)(2)(K)(ii) of this title’’.


Subsec. (a)(1)(K). Pub. L. 105–33, § 4008(m)(3)(G) [(F)], substituted ‘‘section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(ii) of this title’’ for ‘‘section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(ii) of this title’’.


Subsec. (a)(2)(A). Pub. L. 103–432, § 156(a)(2)(E), struck out ‘‘, with respect to items and services furnished in connection with obtaining a second opinion required under section 1395cc–19(c)(2) of this title, if the second opinion was in disagreement with the first opinion.’’, after ‘‘section 1395x(s)(10)(A) of this title’’.

Subsec. (d). Pub. L. 103–432, § 1006(b)(1)(A), substituted ‘‘long-stay cases in a hospital’’ for ‘‘long-stay cases in a hospital or skilled nursing facility’’, ‘‘such hospital’’ for ‘‘such hospital or facility’’ in two places, ‘‘period of such services’’ for ‘‘period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be’’, and ‘‘notice to the hospital’’ for ‘‘notice to the hospital or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement’’.


Subsec. (h)(1). Pub. L. 103–396 inserted before period at end ‘‘, except that, in so applying such sections and in applying section 406(i) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively’’.


Pub. L. 102–54 substituted ‘‘Secretary of Veterans Affairs’’ for ‘‘Administrator of Veterans Affairs’’.


Subsec. (a)(1)(H). Pub. L. 101–508, § 4157(c)(2), inserted ‘‘services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and’’ after ‘‘and other than’’.

Subsec. (a)(1)(I). Pub. L. 101–508, § 4008(m)(3)(B), inserted ‘‘and to meet the requirements of such section’’ after ‘‘section 1395dd of this title’’.


Subsec. (e). Pub. L. 101–508, § 4162(b), substituted ‘‘include—’’ and ‘‘services described by section 1395cc–19(c)(2) of this title, certified nurse-midwife services, qualified psychologist services, and other than’’ for ‘‘include—’’ and ‘‘such reviews,’’ at end.


Subsec. (a)(1)(G). Pub. L. 101–239, § 6003(g)(3)(D)(xii)(IV), inserted ‘‘or in the case of rural primary care’’ before ‘‘to accept as payment in full for’’.

Subsec. (a)(1)(H). Pub. L. 101–239, § 6003(g)(3)(D)(xii)(VI), inserted ‘‘and in the case of rural primary care’’ before ‘‘to accept as payment in full for’’.

Subsec. (a)(1)(I). Pub. L. 101–239, § 6003(g)(3)(D)(xii)(VIII), inserted ‘‘and in the case of rural primary care’’ before ‘‘to accept as payment in full for’’.

Subsec. (a)(1)(J). Pub. L. 101–239, § 6003(g)(3)(D)(xii)(X). Pub. L. 101–239, § 6003(g)(3)(D)(xii)(X), inserted ‘‘for (or meets the requirements of such section through the operation of section 1395x(g)(3)(D)(xii)(X), or if, in the case of a public health agency, such agency meets the requirements of section 1395cc–19(c)(2) of this title (or meets the requirements of such section through the operation of section 1395cc–19(c)(2) of this title, only with respect to the furnishing of outpatient physical therapy services as therein defined or (through the operation of section 1395cc–19(c)(2) of this title) with respect to the furnishing of outpatient occupational therapy services’’.

primary care hospitals which provide rural primary care hospital services” after “payment may be made under this subchapter.”

Subsec. (g). Pub. L. 101–239, § 4018(a)(1), amended subpar. (I) generally. Prior to amendment, subpar. (I) read as follows: “in the case of a hospital and in the case of a rural primary care hospital, to comply with the requirements of section 1395dd of this title to the extent applicable,”.

Pub. L. 101–239, § 6003(g)(3)(D)(xii)(III), inserted “and in the case of a rural primary care hospital” after “hospital”.


Subsec. (a)(2)(A). Pub. L. 101–234, § 101(a), inserted “1395m(c),” after “1395m(a)”.

Par. (4) as (3) and struck out former par. (3) which read as follows: “The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1395l(b) of this title) of such provider, is a person described in section 1320a–5(a) of this title.”

Subsec. (a)(3)(C)(xi). Pub. L. 100–203, § 4097(b), as amended by Pub. L. 100–360, § 411(j)(4)(C)(vi), inserted “money penalty” for “monetary penalty” in first sentence and amended second sentence generally. Prior to amendment, second sentence read as follows: “Such a penalty shall be imposed in the same manner as civil monetary penalties imposed under section 1320a–5(a) of this title with respect to actions described in subsection (a) of that section.”

Subsec. (f). Pub. L. 100–485, § 608(f)(1), struck out subsec. (f) which provided for termination or decertification and alternatives thereto.


1987—Subsec. (a)(1)(F)(iii)(III). Pub. L. 100–203, § 4097(a), substituted “1986” for “1985” and inserted “and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year” after “inflation”.


Subsec. (a)(2)(A). Pub. L. 100–203, § 4062(d)(4), inserted at end “Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395m(b) of this title and 20 percent of the payment basis described in section 1395m(a)(2) of this title.”

Subsec. (a)(3)(C)(i). Pub. L. 100–203, § 4097(b), as amended by Pub. L. 100–360, § 411(j)(5), substituted cls. (i) and (ii) for “with a risk-sharing contract under section 1395mm of this title,”.

Subsec. (a)(3)(C)(ii). Pub. L. 100–203, § 4097(b), as amended by Pub. L. 100–360, § 411(j)(5), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “shall be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations’ conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of subchapter XI of this chapter.”

Subsec. (a)(3)(C)(iii). Pub. L. 100–203, § 4097(b), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1395l(b) of this title) of such provider, is a person described in section 1320a–5(a) of this title.”

Subsec. (a)(3)(C)(iv). Pub. L. 100–360, § 411(j)(4)(C)(vi), substituted “money penalty” for “monetary penalty” in first sentence and amended second sentence generally. Prior to amendment, second sentence read as follows: “Such a penalty shall be imposed in the same manner as civil monetary penalties imposed under section 1320a–5(a) of this title.”
1986—Subsec. (a)(1)(H). Pub. L. 99–509, § 9335(e)(1)(A), redesignated existing provisions as cl. (i) and in cl. (i), as so redesignated, redesignated former cls. (i) to (iii) as subcls. (I) to (III), and added cl. (ii).


Relating to agreement not to charge for certain items and services as subpar. (K).

(a)(4) for “or (a)(3)”.


Subsec. (a)(2)(A). Pub. L. 99–509, § 9401(b)(2)(F), inserted “, with respect to items and services furnished in connection with obtaining a second opinion required under section 1320a–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),” after “1395x(s)(10)(A) of this title” in last sentence.


Subsec. (e). Pub. L. 99–509, § 9337(c)(2), inserted in second sentence “(or meets the requirements of such section through the operation of section 1395x(g) of this title)” in two places, and inserted “or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services” after “as therein defined”.


Subsec. (a)(1)(F). Pub. L. 98–969, § 2315(d), substituted “(b), (c), or (d)” for “(c) or (d)”.

Pub. L. 98–369, § 2347(a)(1), substituted “maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located under which the organization” for “maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located under which the organization)”.

Subsec. (a)(2)(A). Pub. L. 98–369, § 2369(a), inserted “and with respect to clinical diagnostic laboratory tests” after “section 1395x(s)(10) of this title”.

Pub. L. 98–369, § 2321(c), added cl. (ii). In subcl. (I), which are durable medical equipment furnished as home health services” after “part B of this subchapter”. Pub. L. 98–369, § 2322(b)(3), substituted “section 1395x(s)(10)(A) of this title” for “section 1395x(s)(10) of this title”.

Subsec. (b)(3). Pub. L. 98–369, § 2335(d)(1), substituted “(including inpatient psychiatric hospital services)” for “(including tuberculosis hospital services and inpatient psychiatric hospital services)”.

Pub. L. 98–369, § 2354(b)(34), realigned margin of par. (3).

Subsec. (b)(4). Pub. L. 98–369, § 2348(a), substituted “more than 30 days after such effective date” for “after the calendar year in which such termination is effective”.

Subsec. (d). Pub. L. 98–369, § 2335(d)(2), substituted “(including inpatient psychiatric hospital services)” for “(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services)”.

1983—Subsec. (a)(1). Pub. L. 98–21, § 602(c)(2), inserted provision at end of par. (1) that in the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization’s contract with the Secretary under part B of subchapter XI terminates on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

Subsec. (a)(1)(F). Pub. L. 98–21, § 602(d)(1), which provided that, effective Oct. 1, 1984, subpar. (F) is amended by substituting “(with an organization)” for “if there is such an organization”, was repealed by Pub. L. 98–369, § 2347(a)(2), effective July 18, 1984.

Subsec. (a)(1)(F) to (H). Pub. L. 98–21, § 602(f)(1), added subpars. (F) to (H).

Subsec. (a)(2)(A). Pub. L. 98–21, § 602(d)(2), inserted “and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1395ww(d) of this title” after “(except with respect to emergency services)” in provision preceding subcl. (1).


Subsec. (a)(2)(B)(i). Pub. L. 97–248, § 122(g)(2), inserted “and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1395ww(d) of this title” after “(except with respect to emergency services)” in provision preceding subcl. (1).

1981—Subsec. (a)(1)(B). Pub. L. 97–35 struck out provision following subpar. (D) which provided that an agreement with a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)” after “may be terminated”.

Subsec. (b)(4)(A). Pub. L. 97–248, § 122(g)(6), inserted “or hospice care” after “home health services”.

1980—Subsec. (a)(3)(A). Pub. L. 96–611 inserted provision that a provider of services may not impose a charge under clause (i) of the first sentence of this subsection for “a home health service”.

for items and services furnished individuals with end stage renal disease on the basis established by the Secretary.


Subsec. (b)(2)(C), Pub. L. 95–142, § 8(b), designated existing provisions as subcl. (i) and added subcl. (ii).

Subsec. (b)(2)(F), Pub. L. 95–142, § 8(b)(3), substituted “of a quality which fails to meet professionally recognized standards of health care” for “harmful to individuals or to be of a grossly inferior quality”, and struck out provisions relating to approval by an appropriate program review team.

Subsec. (c)(2), Pub. L. 95–210 substituted “section 1396i(a) of this title” for “section 1396i of this title”.

1972—Subsec. (a)(1). Pub. L. 92–603, §§ 227(d)(2), 249A(d), 278(a)(17), (b)(18), 281(c), substituted “Any provider of services (except a fund designated for purposes of section 1396(g) and section 1395(e)(1) of this title) for “Any provider of services”, “skilled nursing facility” for “extended care facility”, inserted provision that the agreement be for a term of not to exceed 12 months with an allowable extension of 2 months under specified circumstances, redesignated subpar. (B) as (C) and added subpar. (B).


Subsec. (b). Pub. L. 92–603, §§ 229(b), 249A(c), 278(a)(17), inserted “(and in the case of an extended care facility, prior to the end of the term specified in subsection (a)(1) of this section)” in provision preceding par. (1), in par. (2), added cl. (D) to (F), and in par. (3), substituted “(including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to” for “(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after” and substituted “skilled nursing facility” for “extended care facility”.

Subsec. (c). Pub. L. 92–603, § 229(d), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(C), Pub. L. 92–603, § 223(g)(2), substituted “this subparagraph” for “clause (ii) of the preceding sentence”.

Subsec. (a)(2)(D), Pub. L. 92–603, § 223(g)(1), added subpar. (D).

Subsec. (b). Pub. L. 92–603, §§ 229(b), 249A(c), 278(a)(17), inserted “(and in the case of an extended care facility, prior to the end of the term specified in subsection (a)(1) of this section)” in provision preceding par. (1), in par. (2), added cl. (D) to (F), and in par. (3), substituted “(including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to” for “(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after” and substituted “skilled nursing facility” for “extended care facility”.

Subsec. (c). Pub. L. 92–603, § 229(d), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d). Pub. L. 92–603, § 278(a)(17), substituted “skilled nursing facility” for “extended care facility” and “a” for “an”.


Pub. L. 90–928, § 133(b), authorized a provider of services to charge for blood in accordance with its customary practices, included, in addition to whole blood for which a provider of services may charge, equivalent quantities of packed red blood cells, and provided that blood furnished an individual will be deemed replaced when the provider is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the three pint deductible applies.

Subsec. (e). Pub. L. 90–928, § 133(c), added subsec. (e).

**Effective Date of 1999 Amendment**


**Effective Date of 1997 Amendments**

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

Amendment by section 4302(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4301(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4302(a) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to the entry and renewal of contracts on or after such date, see section 4302(c) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4301(c)(1)(A) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4301(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4301(c)(1)(B) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4301(e) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4511(a)(2)(D) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Jan. 1, 1999, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4511(a)(3) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1999, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Section 4511(e) of Pub. L. 105–33 provided that: “The amendments made by subsection (a) amending this section shall apply to provider agreements entered into, renewed, or extended on or after such date not later than one year after the date of the enactment of this Act (Aug. 5, 1997) as the Secretary of Health and Human Services specifies.”

Amendment by section 4714(b)(1) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

**Effective Date of 1994 Amendments**

Section 106(b)(2) of Pub. L. 103–432 provided that: “The amendments made by paragraph (1) amending this section and section 1395f of this title shall take effect as if included in the enactment of OBRA–1987 (Pub. L. 100–203).”

Amendment by section 147(e)(7) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Amendment by section 156(a)(2)(E) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.


**Effective Date of 1990 Amendment**

Section 4008(b)(4) of Pub. L. 101–508 provided that: “The amendments made by this subsection [amending
this section and section 1395dd of this title] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1986].


Amendment by section 4157(c)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4162(b) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4162(e)(1) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4206(a) of Pub. L. 101–508 applicable with respect to items dispensed on or after Jan. 1, 1990, see section 4206(e)(1) of Pub. L. 101–508, set out as a note under section 1395k of this title.

**Effective Date of 1989 Amendments**

Section 6018(b) of Pub. L. 101–239 provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the first day of the first month that begins more than 90 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date."

Amendment by section 6121(c)(3) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6121(e)(4) of Pub. L. 101–239, set out as a note under section 1395m of this title.

Amendment by section 191(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 191(d) of Pub. L. 101–234, set out as a note under section 1395k of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1323a–7a of this title.

**Effective Date of 1988 Amendments**


Amendment by section 104(d)(5) of 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.

Amendment by section 202(h)(1) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(2)(C), (g)(1)(D), (i)(4)(C)(vi), (j)(1)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA: Effective Date note under section 106 of Title I, General Provisions.

Section 411(c)(2)(A)(ii) of Pub. L. 100–360 provided that: "The amendment made by clause (i) [amending this section] shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act [July 1, 1988]."

**Effective Date of 1987 Amendments**

Amendment by section 4012(a) of Pub. L. 100–203 applicable to admissions occurring on or after Apr. 1, 1988, or, if later, the earliest date the Secretary can provide the information required under section 4012(a)(1), (2), (3), (4) of Pub. L. 100–203 [42 U.S.C. 1395mm note] in machine readable form, see section 4012(d) of Pub. L. 100–203, set out as a note under section 1363m of this title.

Amendment by section 4062(d)(4) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Section 4085(x)(17) of Pub. L. 100–203 provided that the amendment made by such section 4085(x)(17) is effective as if included in the enactment of Pub. L. 99–509.

Section 4097(c) of Pub. L. 100–203 provided that: "The amendments made by this section [amending this section] shall apply with respect to fiscal years beginning on or after October 1, 1988."

Amendment by section 4212(e)(4) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396f of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396f of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1395a–7 of this title.

**Effective Date of 1986 Amendments**

Section 233(b) of Pub. L. 99–509 provided that: "The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring after June 30, 1987."


Section 9305(b)(2) of Pub. L. 99–509 provided that: "The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act [subsec. (a)(1)(M) of this section] not later than six months after the date of the enactment of this Act [Oct. 21, 1986]." The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide."

Amendment by section 9320(b)(2) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(1), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Section 9333(e)(2) of Pub. L. 99–509 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to agreements under section 1866(a) of the Social Security Act [subsec. (a) of this section] as of October 1, 1987."
Section 9353(e)(3)(A) of Pub. L. 99–509 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to provider agreements as of Oct. 1, 1997.”

Amendment by section 912(a)(1) of Pub. L. 99–272 effective on first day of first month that begins at least 90 days after Apr. 7, 1986, see section 912(c) of Pub. L. 99–272, set out as a note under section 1395dd of this title.

Section 912(b) of Pub. L. 99–272, as amended by Pub. L. 99–514, title XVIII, §1895(b)(6), Oct. 22, 1986, 100 Stat. 2933, provided that: “The amendments made by subsection (a) [amending this section] shall apply to impatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.”

Section 9402(c)(1) of Pub. L. 99–272 provided that: “The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].”

Amendment by section 9439(b) of Pub. L. 99–272 effective Apr. 7, 1986, see section 9439(c) of Pub. L. 99–272, set out as a note under section 13238–3 of this title.

**Effective Date of 1984 Amendment**

Amendment by section 2303(f) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395yy of this title, see section 2303(j)(1), (3) of Pub. L. 98–369, set out as a note under section 1395yy of this title.

Amendment by section 2315(d) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendment note under section 1395ww of this title.

Amendment by section 2321(c) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395i of this title.

Amendment by section 2322(b)(3) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2322(d) of Pub. L. 98–369, set out as a note under section 1395i of this title.

Amendment by section 2335(d) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395i of this title.

Amendment by section 2347(a) of Pub. L. 98–369 effective July 18, 1984, see section 2347(d) of Pub. L. 98–369, set out as a note under section 1320c–2 of this title.

Section 2348(b) of Pub. L. 98–369 provided that: “The amendment made by this section [amending this section] shall apply to terminations issued on or after the date of the enactment of this Act [July 18, 1984].”

Amendment by section 2354(b)(33), (34) 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 1320c–1 of this title.

**Effective Date of 1983 Amendments**


Amendment by section 602(2) of 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 to do so, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

**Effective Date of 1982 Amendment**

Amendment by section 122(g)(5), (6) 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, set out as a note under section 1395cc of this title.

**Effective Date of 1980 Amendment**

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395cc of this title.

**Effective Date of 1978 Amendment**

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility’s or provider’s first account 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 Amendments**

Section 2(a) of Pub. L. 95–210 provided that:

“(1) The amendments made by this section [amending this section and sections 1396a, 1396d, and 1396i of this title] shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [subchapter XIX of this chapter], on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act [Dec. 13, 1977].

“(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [subchapter XIX of this chapter] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title [subchapter] to such extent that the failure to meet these additional requirements before the first day of the first calendar quarter beginning after the
close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 13, 1977]."

Amendment by section 3(b) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 8(b) of Pub. L. 95–142 (amending this section) applicable with respect to contracts, agreements, etc., made on and after first day of fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–5 of this title.

Amendment by section 13(b)(3) of Pub. L. 95–142 effective Oct. 25, 1977, see section 13(c) of Pub. L. 95–142, set out as a note under section 1395y of this title.

Section 15(b) of Pub. L. 95–142 provided that: “The amendments made by subsection (a) [amending this section] shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 22(e), (g) of Pub. L. 92–603 effective with respect to accounting periods beginning after Dec. 31, 1972, see section 22(b) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 22(d)(2) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 22(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Section 249A(e) of Pub. L. 92–603 provided that: “The provisions of this section [enacting section 1396f of this title and amending this section] shall be effective with respect to agreements filed with the Secretary under section 1866 of the Social Security Act [this section] by skilled nursing facilities (as defined in section 1861(j) of such Act [section 1395x(j) of this title]) before, on, or after the date of enactment of this Act [Oct. 30, 1972], but accepted by him on or after such date.”

Amendment by section 281(c) of Pub. L. 92–603 applicable in the case of notices sent to individuals after 1968, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395g of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(12) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395f of this title.

Amendment by section 133(c) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395x of this title.

Amendment by section 135(b) of Pub. L. 90–248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub. L. 90–248, set out as a note under section 1395e of this title.

EFFECT ON STATE LAW

Section 4206(c) of Pub. L. 101–508 provided that: “Nothing in subsections (a) and (b) [amending this section and sections 1395 and 1395mm of this title] shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.”

REPORTS TO CONGRESS ON NUMBER OF HOSPITALS TERMINATING OR NOT RENEWING PROVIDER AGREEMENTS

Section 233(c) of Pub. L. 99–576 provided that: “(1) The Secretary of Health and Human Services shall periodically submit to the Congress a report on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [this section] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].

“(2) Not later than October 1, 1987, the Administrator of Veterans’ Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report regarding implementation of this section [amending this section]. Thereafter, the Administrator shall notify such committees if any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons described in that paragraph.”

Section 9122(d) of Pub. L. 99–272 provided that: “The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [this section] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].”

DELAY IN IMPLEMENTATION OF REQUIREMENT THAT HOSPITALS MAINTAIN AGREEMENTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

Section 2347(b) of Pub. L. 98–369 provided that: “Notwithstanding section 604(a)(2) of the Social Security Amendments of 1983 (section 604(a)(2) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 1395ww of this title), the requirement that a hospital maintain an agreement with a utilization and quality control peer review organization contained in section 166(a)(1)(F) of the Social Security Act [subsec. (a)(1)(F) of this section], shall become effective on November 15, 1983.

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS’ SERVICES

For authority to waive the requirements of subsection (a)(1)(H) of this section for any cost period prior to Oct. 1, 1986, where immediate compliance would threaten the stability of patient care, see section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title.

PRIVATE SECTOR REVIEW INITIATIVE

Section 119 of Pub. L. 97–248 provided that: “(a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVII of the Social Security Act [this subchapter] and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

“(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act [this subchapter], such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title [this section and section 1865p of this title], from collecting any payments from beneficiaries unless otherwise provided under such title.”

AGREEMENTS FILED AND ACCEPTED PRIOR TO OCT. 30, 1972, DEEMED TO BE FOR SPECIFIED TERM ENDING DEC. 31, 1973

Section 249A(f) of Pub. L. 92–603 provided that: “Notwithstanding any other provision of law, any agreement, filed by a skilled nursing facility (as defined in section 1861(j) of the Social Security Act [section 1395x(j) of this title]) with the Secretary under section 1866 of such Act [this section] and accepted by him prior to the date of enactment of this Act [Oct. 30, 1972], which was in effect on such date shall be deemed to be for a specified term ending on December 31, 1973.”

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1320a–7a, 1320b–16, 1395f, 1395i–3, 1395f, 1395m, 1395w–22, 1395x, 1395y, 1395dd, 1395mm, 1395tt, 1395vv, 1395ww, 1395x, 1395y, 1395dd, 1395mm, 1395tt, 1395vv, 1395ww,
§ 1395dd. Examination and treatment for emergency medical conditions and labor (1) In general

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

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

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

(2) Refusal to consent to treatment

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

(3) Refusal to consent to transfer

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

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

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

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

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

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

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

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

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

(B) in which the receiving facility—

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

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

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

1So in original. Probably should be followed by a comma.
(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual’s condition or other information, including a hospital’s obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs.

The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) Definitions

In this section:

(1) The term ‘emergency medical condition’ means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

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So in original. Probably should be “woman”.

3So in original. Probably should be “woman”.
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term “participating hospital” means hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term “transfer” means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term “hospital” includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual’s method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(ii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

Subsec. (d)(2)(A). Pub. L. 101–508, § 4008(b)(1), (2), substituted “negligently” for “knowingly” and inserted “(or not more than $25,000 in the case of a hospital with less than 100 beds)” after “$50,000.”


Subsec. (i). Pub. L. 101–508, § 4207(k)(3), formerly § 4027(k)(3), as renumbered by Pub. L. 103–332, § 1660(d)(4), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: “A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.”


Subsec. (a). Pub. L. 101–239, § 6211(b)(2)(B), which directed the amendment of subsec. (a) by striking out “or to determine if the individual is in active labor (within the meaning of subsection (e)(2) of this section)” after “exists”, Pub. L. 101–239, § 6211(a), substituted “hospital’s emergency department, including ancillary services routinely available to the emergency department,” for “hospital’s emergency department.”


Subsec. (b)(2). Pub. L. 101–239, § 6211(h)(2)(D)(ii), struck out “and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual in active labor (within the meaning of subsection (e)(2) of this section)” after “exists”. Pub. L. 101–239, § 6211(a), substituted “hospital’s emergency department, including ancillary services routinely available to the emergency department,” for “hospital’s emergency department.”

Subsec. (b)(3). Pub. L. 101–239, § 6211(b)(2), inserted “and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual of such examination and treatment,” after “in that paragraph”, substituted “and treatment,” for “or treatment:”, and inserted at end “The hospital shall take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse such examination and treatment.”


Subsec. (c)(1). Pub. L. 101–239, § 6211(c)(4), (g)(1)(B), (h)(1), in introductory provisions, substituted “an individual” for “a patient”, “subsection (e)(3)(B) of this section” for “subsection (e)(4)(B) of this section” or is in active labor”, and “the individual” for “the patient”, and inserted at end “A certification described in clause (i) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.”

Subsec. (c)(1)(A)(iii). Pub. L. 101–239, § 6211(c)(1), (g)(1)(B), substituted the “individual” for the “patient”, “the individual’s behalf” for “the patient’s behalf”, and “after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility” for “requests that the transfer be effected.”

Subsec. (c)(1)(A)(ii). Pub. L. 101–239, § 6211(c)(2)(B), (3), (g)(1)(B), substituted “a certification that based upon the information available at the time of transfer for “or”, or other qualified medical personnel when a physician is not readily available in the emergency department has signed a certification that based upon the reasonable risks and benefits to the patient, and based upon the information available at the time” and “individual and, in the case of labor, to the unborn child” for “individual’s medical condition”.


Subsec. (c)(2)(B). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (A) as (B) and substituted “the individual” for “the patient” in cls. (i) and (ii). Former subpar. (B) redesignated (C).

Subsec. (c)(2)(C). Pub. L. 101–239, § 6211(c)(5)(A), (d), redesignated subpar. (B) as (C) and substituted “sends to” for “provides” and “all medical records (or copies thereof) related to the emergency medical condition observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment” for “with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital”. Former subpar. (C) redesignated (D).

Subsec. (c)(2)(D). Pub. L. 101–239, § 6211(c)(5)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (D) as (E) and substituted “individuals” for “patients”.

Subsec. (d)(2)(B). Pub. L. 101–239, § 6211(e)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “The responsible physician in a participating hospital with respect to the hospital’s violation of this requirement of this subsection is subject to the sanctions described in section 1395aa(a)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.”

Subsec. (d)(2)(C). Pub. L. 101–239, § 6211(e)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: “As used in this paragraph, the term ‘responsible physician’ means, with respect to a hospital’s violation of a requirement of this section, a physician who—

(i) is employed by, or under contract with, the participating hospital, and

(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.”

Subsec. (e)(1). Pub. L. 101–239, § 6211(h)(1)(A), substituted “means—” and added subpar. (D) which defined “active labor”. Pub. L. 101–239, § 6211(h)(1)(A), redesignated (D) as (C) and struck out former subpar. (C) which defined “active labor”.

Subsec. (e)(2). Pub. L. 101–239, § 6211(h)(1)(B), (E), redesignated par. (3) as (2) and struck out former par. (2) which defined “active labor”.


Subsec. (e)(4)(A). Pub. L. 101–239, § 6211(h)(1)(C), substituted “emergency medical condition described in paragraph (1)(A)” for “emergency medical condition”, “likely to result from or occur during” for “likely to result from”, and “from a facility, or, with respect to an emergency medical condition described in paragraph...
(1)(B), to deliver (including the placenta)” for “from a facility”.


L. 101–239, § 6211(d)(2), substituted “individual” for “a patient” in two places.


Pub. L. 101–239, § 6211(g)(2), substituted “the previous section” for “this paragraph”, and “or” for “and”. Former section 1395ee of this title, redesignated as section 1395ee–1 of this title.

Subsec. (f). Pub. L. 101–239, § 6211(h)(3), redesignated subsection (f) as (g), redesignated former subsection (g) as (f), and added subsec. (h).

§ 1395ee. Practicing Physicians Advisory Council

(a) Appointment

The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this section referred to as the “Council”) to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians’ services under this subchapter in a calendar year, to serve for the terms of its members, or until a successor has been appointed and qualified.

Effective Date

This section is effective on the first day of the first month that begins more than 180 days after the date of the publication of this Act in the Federal Register.


Subsec. (b)(2). Pub. L. 101–239, § 6211(i)(2), redesignated paragraph (b)(2) as (3), redesignated former section 1395ee of this title as section 1395ee–1 of this title, and added subsec. (4).


Effective Date

Amendment by Pub. L. 101–508 effective as if included in the enactment of the Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272, set out as a reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Effective Date

Amendment by Pub. L. 100–360, § 411(b)(8)(A)(ii), July 1, 1988, 102 Stat. 772, provided that: “The amendments made by this subsection shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987].”

Effective Date

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, set out as a reference to OBRA; Effective Date note under section 162 of Title 26, Internal Revenue Code.

Effective Date

Section 912(c) of Pub. L. 99–272 provided that: “The amendments made by this section [enacting this subtitle and amending section 1385cc of this title] shall take effect on or after the date of the enactment of this Act [Apr. 7, 1986].”

Inspector General Study of Prohibition on Hospital Employment of Physicians

Section 4008(c) of Pub. L. 101–508 directed Secretary of Health and Human Services (acting through Inspector General of Department of Health and Human Services) to conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1387 of the Social Security Act (this section) relating to the examination and treatment of individuals with an emergency medical condition and women in labor, with Secretary to submit a report to Congress on the study not later than 1 year after Nov. 5, 1990.
the previous year. At least 11 of the members of the Council shall be physicians described in section 1395ee(r)(1) of this title and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

(b) Meetings

The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

(c) Reimbursement of expenses

Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this subchapter.


Prior Provisions


Termination of Advisory Councils

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by Congress, its duration is otherwise provided by law. See section 3(2) and 14 of Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 776, set out in the Appendix to Title 5, Government Organization and Employees.

§1395ff. Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A or part B of this subchapter, and any other determination with respect to a claim for benefits under part A of this subchapter or a claim for benefits under part B of this subchapter shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals; provider representation of beneficiaries

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter or section 1395i–2 of this title,

(C) the amount of benefits under part A or part B of this subchapter (including a determination where such amount is determined to be zero), or

(D) any other denial (other than under part B of subchapter XI of this chapter) of a claim for benefits under part A of this subchapter or a claim for benefits with respect to home health services under part B of this subchapter,

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(h) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. Sections 406(a), 1302, and 1385(h) of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1395pp(a)(2) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.

(2) Notwithstanding paragraph (1)(C) and (1)(D), in the case of a claim arising—

(A) under part A of this subchapter, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $1,000; or

(B) under part B of this subchapter, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $500 (or $100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.
(3) Review of any national coverage determination under section 1395cc(a)(1) of this title respecting whether or not a particular type or class of items or services is covered under this subchapter shall be subject to the following limitations:

(A) Such a determination shall not be reviewed by any administrative law judge.

(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5 or section 1395hh(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item or service is covered except upon review of the supplemented record.

(4) A regulation or instruction which relates to a method for determining the amount of payment under part B of this subchapter and which was initially issued before January 1, 1981, shall not be subject to judicial review.

(5) In an administrative hearing pursuant to paragraph (1), where the moving party alleges that there are no material issues of fact in dispute under part B of this subchapter and which is being conducted under section 1395y(a)(1) of this title, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.


Parts A and B of this subchapter, referred to in subsec. (a) and (b), are classified to sections 1395cc et seq., respectively, of this title.

Part B of subchapter XI of this chapter, referred to in subsec. (b)(1)(D), is classified to section 1320c et seq. of this title.

AMENDMENTS

1997—Subsec. (b)(2)(B). Pub. L. 100–203 § 4085(i)(19) inserted “or $100 in the case of home health services” after “$500.”

1994—Subsec. (b)(1). Pub. L. 98–369 struck out “, except that, in so applying such sections and in applying section 405(g) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively” after “section 405(g) of this title” in closing provisions.

1987—Subsec. (a). Pub. L. 100–203 § 4082(b)(18), inserted “or any other determination with respect to a claim for benefits under part A of this subchapter” before “shall”.

Subsec. (b)(2). Pub. L. 100–203, § 4085(i)(19), inserted “and (1)(D)” after “paragraph (1)(C)” in two places.

Subsec. (b)(3)(B). Pub. L. 100–203, § 4082(a), substituted “section 553” for “chapter 5”.

Subsec. (b)(5). Pub. L. 100–203, § 4082(b), added par. (5).

Subsec. (c). Pub. L. 100–93 struck out subsec. (c) which read as follows: “Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g) of this title.”


Pub. L. 99–509, § 9313(b)(1)(A), inserted “and any other determination with respect to a claim for benefits under part A of this subchapter” before “shall”.

Subsec. (b)(1). Pub. L. 99–509, § 9341(a)(1), in concluding provisions, inserted at end “Sections 406(a), 1302, and 1395hh of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subchapter with respect to the issue described in section 1395ppa(a) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subchapter, the person may not impose any financial liability on such individual in connection with such representation.”


Subsec. (b)(2). Pub. L. 99–509, § 9341(a)(1)(C), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “(Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to a beneficiary or the recipient thereof to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual under this subsection with respect to the issue described in section 1395ppa(a) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services of items involved in the appeal. If a person furnishes services or items to an individual and represents an individual under this subchapter, the person may not impose any financial liability on such individual in connection with such representation.”


1984—Subsec. (b)(1)(B). Pub. L. 98–369 struck out the comma before “or section 1395i–2” and struck out “, or section 1319” after “section 1395i–2 of this title.”

1972—Subsec. (b). Pub. L. 92–953 redesignated existing provisions as par. (1), generally amended conditions under which a dissatisfied individual shall be entitled to a hearing by Secretary and to judicial review of final decision of Secretary after such hearing, and added par. (2).

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1996, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 461(f) of Pub. L. 100–203, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Effective Date of 1987 Amendments

Section 3082(e)(1), (2) of Pub. L. 100–203 provided that:

“(1) The amendment made by subsection (a) (amending this section) shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

“(2) The amendment made by subsection (b) (amending this section) shall apply to requests for hearings filed after the end of the 60-day period beginning on the date of the enactment of this Act.”

Amendment by Pub. L. 100–95 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 16(a) of Pub. L. 100–95, set out as a note under section 1320a–7 of this title.

Effective Date of 1986 Amendment

Section 9313(b)(2) of Pub. L. 99–509 provided that:

“...amendments made by subsection (a) (amending this section) shall take effect on the date of the enactment of this Act [Oct. 21, 1986].”

Section 9341(b) of Pub. L. 99–509 provided that: “...amendments made by this subsection (amending this section and sections 1395u and 1395p of this title) shall apply to items and services furnished on or after January 1, 1987.”

Effective Date of 1984 Amendment

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right of 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.

Effective Date of 1972 Amendment

Section 299O(b) of Pub. L. 92–603 provided that:

“(1) The provisions of subparagraph (A) and (B) of section 1869(b)(1) of the Social Security Act [subsec. (b)(1A), (B) of this section], as amended by subsection (a) of this section, shall be effective on the date of enactment of this Act [Oct. 30, 1972].

“(2) The provisions of paragraph (2) and subparagraph (C) of paragraph (1) of section 1869(b)(1) of the Social Security Act [subsec. (b)(1C) and (b)(2) of this section], as amended by subsection (a) of this section, shall be effective with respect to any claims under part A of title XVIII of such Act [part A of this subchapter], filed—

“(A) in or after the month in which this Act is enacted [Oct. 1972], or

“(B) before the month in which this Act is enacted [Oct. 1972], but only if a civil action with respect to a final decision of the Secretary of Health, Education, and Welfare on such claim has not been commenced under such section 1869(b)(1), (b)(2) of this section] before such month.”

STUDY OF AGGREGATION RULE FOR CLAIMS FOR SIMILAR PHYSICIANS’ SERVICES

Pub. L. 101–508, title IV, §4113, Nov. 5, 1990, 104 Stat. 1388–64, directed Secretary of Health and Human Services to carry out a study of the effects of permitting the aggregation of claims that involve common issues of law and fact furnished in the same carrier area to more than two or more individuals by two or two physicians within the same 12-month period for purposes of appeals provided for under subsection (b) of this section, and to report on the results of such study and any recommendations to Congress by Dec. 31, 1992.

MEDICARE HEARINGS AND APPEALS

Section 4082(e)(1), (2) of Pub. L. 100–203 provided that:

“(1) MAINTAINING CURRENT SYSTEM FOR HEARINGS AND APPEALS.—Any hearing conducted under section 1861(h)(1) of the Social Security Act [subsec. (b)(1) of this section] prior to the earliest of the date on which the Secretary of Health and Human Services submits the report required to be submitted by the Secretary under subsection (b)(1) or September 1 shall be conducted by Administrative Law Judges of the Office of Hearings and Appeals of the Social Security Administration in the same manner as are hearings conducted under section 196b(1) of such Act [section 405(b)(1) of this title].

“(b) STUDY AND REPORT ON USE OF TELEPHONE HEARINGS.—

“(1) The Secretary of Health and Human Services and the Comptroller General of the United States shall each conduct a study on holding hearings under section 1861(h)(1) of the Social Security Act [subsec. (b)(1) of this section] by telephone and shall each report the results of the study not later than 6 months after the date of enactment of this Act [Dec. 22, 1987].

“(2) The studies under paragraph (1) shall focus on whether telephone hearings allow for a full and fair evidentiary hearing, in general, or with respect to any particular category of claims and shall examine the possible improvements to the hearing process (such as cost-effectiveness, convenience to the claimant, and reduction in time under the process) resulting from the use of such hearings as compared to the adoption of other changes to the process (such as expansions in staff and resources).”

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1366i–5, 1365f, 1365m, 1365u, 1365w–4, 1395pp, 1365ww, 1365yy, 1365fff of this title; title 45 section 231f.

§ 1395gg. Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals

(a) Payments to providers of services or other person regarded as payment to individuals

Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Incorrect payments on behalf of individuals; payment adjustment

Where—

(1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1395f(e) of this title to a provider of services or other person for items or services furnished an individual, proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case may be,

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case...
may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974 (45 U.S.C. 231 et seq.)) the amount of the overpayment in which to adjust another individual. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct adjustment paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(c) Exception to subsection (b) payment adjustment

There shall be no adjustment as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing subsequent payments to an individual who is without fault is entitled as provided in subsection (b)(4) of this section, if such adjustment (or recovery) would defeat the purposes of subchapter II or subchapter XVIII of this chapter or would be against equity and good conscience. Adjournment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this subchapter) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this subchapter by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(d) Liability of certifying or disbursing officer for failure to recoup

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) of this section or where adjustment under subsection (b) of this section is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) Settlement of claims for benefits under this subchapter on behalf of deceased individuals

If an individual, who received services for which payment may be made to such individual under this subchapter, dies, and payment for such services was made (other than under this subchapter), and the individual died before any payment due him under this subchapter with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this subchapter is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person or per-
sons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child); or
(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or
(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) Settlement of claims for section 1395k benefits on behalf of deceased individuals

If an individual who received medical and other health services for which payment may be made under section 1395k(a)(1) of this title dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, payment for such services shall be made to such person or persons, and
(2) if the person or persons who furnished the services do not agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations), but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

(g) Refund of premiums for deceased individuals

If an individual, who is enrolled under section 1395i–2(c) of this title or under section 1395p of this title, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e) of this section.


REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (b), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 92–455, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

AMENDMENTS

Subsec. (f)(1), (2). Pub. L. 100–360, §411(j)(4)(B), substituted "of assignment specified in" for "specified in subclauses (I) and (II) of".
Subsec. (f)(1), (2). Pub. L. 100–203, §4096(a)(2), substituted "to the terms specified in subclauses (I) and (II) of section 1395u(b)(3)(B)(ii) of this title with respect to the services" for "that the reasonable charge is the full charge for the services".
1982—Subsec. (c). Pub. L. 97–248 substituted "section 1395y(a)" for "section 1395y".
1980—Subsec. (f). Pub. L. 96–499 amended subsec. (f) generally, inserting provision for payments to providers of medical and other health services where the person or persons furnishing the services did not agree that the reasonable charge was the full charge for such services, by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4) of this section, if" for "and where", inserted reference generally to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in section 411 of Pub. L. 100–203, and amended subsec. (c).
Subsec. (g). Pub. L. 92–603, §281(a), required that provider of services or other person be without fault with respect to payment of excess over correct amount as prerequisite to adjustment or recovery of incorrect payments.
1972—Subsec. (b). Pub. L. 92–603, §281(a), substituted "where", inserted reference to subsection XVIII of this chapter, and inserted provisions covering the adjustment or recovery of incorrect payments against individuals who are without fault.
1968—Pub. L. 90–248, §154(b), provided for settlement of claims for benefits on behalf of deceased individuals in section catchline.
Subsecs. (e), (f). Pub. L. 90–248, §154(c), added subsecs. (e) and (f).

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4096(a)(2) of Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988.
see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

§ 1395hh. Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term “regulations” means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a) of this section, the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) Publication of certain rules; public inspection; changes in data collection and retrieval

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) of this section and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

AMENDMENTS

1967—Subsec. (a), Pub. L. 100–203, § 4035(b), designated existing provisions as par. (1) and added par. (2).

Subsec. (c). Pub. L. 100–203, § 4035(c), added subsec. (c).

1966—Pub. L. 99–509 designated existing provisions as subsec. (a) and added subsec. (b).

EFFECTIVE DATE OF 1967 AMENDMENT


EFFECTIVE DATE OF 1966 AMENDMENT

Section 9321(e)(3)(A) of Pub. L. 99–509 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act [Oct. 21, 1986].”

REGULATIONS


Section 4539(g) of title IV of Pub. L. 101–508 provided that: “The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle and the amendments made by this subtitle [subtitle A (§§ 4001–4097) of title IV of Pub. L. 101–508, see Tables for classification].”

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1395g, 1395a, 1359f of this title.

§ 1395ii. Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary of Health and Human Services, respectively.


AMENDMENTS

1994—Pub. L. 103–296 inserted before period at end “, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively”.


EFFECTIVE DATE OF 1994 AMENDMENT


EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by 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.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 not applicable to any acts, statements, or representations made or committed prior to Oct. 30, 1972, see section 242(d) of Pub. L. 92–603, set out as an Effective Date note under section 1320a–7b of this title.

§ 1395jj. Designation of organization or publication by name

Designation in this subchapter, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.


§ 1395kk. Administration of insurance programs

(a) Functions of Secretary; performance directly or by contract

Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) Contracts to secure special data, actuarial information, etc.

The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this subchapter.

(c) Oaths and affirmations

In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this subchapter, the Secretary may administer oaths and affirmations.

REFERENCES IN TEXT


AMENDMENTS


EFFECTIVE DATE OF 1974 AMENDMENT


EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by Pub. L. 89–97 applicable to calendar year 1966 or to any subsequent calendar year but only if by October 1 immediately preceding such calendar year the Railroad Retirement Tax Act provides for a maximum amount of monthly compensation taxable under such Act during all months of such calendar year equal to one-twelfth of maximum wages which Federal Insurance Contributions Act provides may be counted for such calendar year, see section 111(e) of Pub. L. 89–97.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in title 45 section 231f.

§ 1395f. Studies and recommendations

(a) Health care of the aged and disabled

The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B of this subchapter; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) Operation and administration of insurance programs

The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B of this subchapter (including a validation of the accreditation process of the Joint Commission on Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972 [42 U.S.C. 1395mm], the experiments and demonstration projects authorized by section 226(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–11 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note]), and shall transmit to the Congress annually a report concerning the operation of such programs.


REFERENCES IN TEXT

Parts A and B of this subchapter, referred to in text, are classified to sections 1395c et seq. and 1395d et seq., respectively, of this title.

Section 226 of the Social Security Amendments of 1972, referred to in subsec. (b), is section 226 of Pub. L. 92–603, which enacted section 1395mm of this title and provisions set out as notes under that section and amended this section and sections 1395f, 1395d, and 1395b of this title.

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

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b), is section 222(a) of Pub. L. 92–603, which enacted provisions set out as notes under section 1395b–1 of this title.

AMENDMENTS


1988—Subsec. (c)(3). Pub. L. 100–647 amended par. (3) generally. Prior to amendment, par. (3) read as follows: “For purposes of carrying out the research program, there are authorized to be appropriated—

(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal year 1987 and $2,500,000 for each of fiscal years 1988 and 1989.”


1984—Subsec. (b), Pub. L. 98–369 struck out “the” after “Joint Commission on”.
1968—Subsec. (b). Pub. L. 90–248 inserted ""(including the experimentation authorized by section 402 of the Social Security Amendments of 1967)"" after ""under parts A and B of this subchapter"".

**Effective Date of 1989 Amendment**

Section 6103(b)(3)(A) of Pub. L. 101–239 provided that the amendment made by that section is effective for fiscal years beginning after fiscal year 1990.

**Effective Date of 1984 Amendment**

Amendment by 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 2954(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

**Effective Date of 1972 Amendment**

Amendment by section 226(d) 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 1395m of this title.

**Study and Report Regarding Utilization of Physician's Services by Medicare Beneficiaries**


"(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

"(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are as follows:

"(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) [parts A and B of this subchapter] resulting from—

"(i) improvements in medical capabilities;

"(ii) advancements in scientific technology;

"(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

"(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

"(B) The rate of usage of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

"(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act (Nov. 29, 1999), the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

"(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

"(A) an analysis and evaluation of the report submitted under paragraph (3); and

"(B) such recommendations as it determines are appropriate.

**Study of Adult Day Care Services**


**Study To Develop a Strategy for Quality Review and Assurance**

Section 9313(d) of Pub. L. 99–509, as amended by Pub. L. 100–360, title IV, § 4685(a)(21)(A), Dec. 22, 1987, 101 Stat. 1330–133, directed Secretary of Health and Human Services to arrange, with the National Academy of Sciences or other appropriate nonprofit private entity, for a study to develop a strategy for reviewing and assuring the quality of care for which payment may be made under this subchapter, specified items to be included in the study, and directed Secretary to submit to Congress, not later than Jan. 1, 1990, a report on the study with recommendations as to how the Secretary may review quality assurances and review activities for services furnished under the medicare program.

**Special Treatment of States Formerly Under Waiver**

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of the waiver, see section 226(d) of Pub. L. 101–234, as amended, set out as a note under section 1395ww of this title.

**Drug Detoxification Medicare Coverage and Facility Incentives**


**Legislative Recommendations Regarding Reimbursement for Optometrists' Services**

Pub. L. 96–499, title IX, § 937(b), Dec. 5, 1980, 94 Stat. 2640, provided that the Secretary of Health and Human Services submit to the Congress by Jan. 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act (this subchapter) for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

**Demonstration Projects, Studies, and Reports: Nutritional Therapy, Second Opinion Cost-Sharing, Services of Registered Dietitians, Services of Clinical Social Workers, Orthopedic Shoes, Respiratory Therapy Services, and Foot Conditions: Grants, Payments, and Expenditures**

Pub. L. 96–499, title IX, § 958, Dec. 5, 1980, 94 Stat. 2648, directed Secretary of Health and Human Services to carry out certain demonstration projects and conduct certain studies as follows: (a) a demonstration project to determine extent to which nutritional therapy in early renal failure could retard the disease with resultant substantive deferment of dialysis, and aspects of making such therapy available under this subchapter, report to Congress to be submitted within twenty-four months of Dec. 5, 1980; (b) demonstration projects with respect to waiving the applicable cost-sharing amounts which beneficiaries under this subchapter had to pay for obtaining a second opinion on having surgery, report to be submitted within one year after Dec. 5, 1980; (c) a study of conditions under which services of registered dietitians could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (d) demonstration projects to determine aspects of making services of clinical social workers more generally available under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (e) a study of methods for providing coverage under part B of this
subchapter for orthopedic shoes for individuals with disabling or deforming conditions requiring special fitting considerations, or requiring special shoes in conjunction with the use of an orthosis or foot support, report to be submitted no later than July 1, 1981; (f) a study of conditions under which services with respect to respiratory therapy could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; and (g) a study analyzing cost effects of alternative approaches to improving coverage under this subchapter for treatment of various types of foot conditions, report to be submitted within twenty-four months of Dec. 5, 1980. Payments and expenditures for such studies and projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund established by section 1395i of this title, and the Federal Supplemental Medical Insurance Trust Fund established by section 1395f of this title.

DEMONSTRATION PROJECT RELATING TO THE TERMINALLY ILL

Pub. L. 96–265, title V, § 506, June 9, 1980, 94 Stat. 475, authorized Secretary of Health and Human Services to provide for participation, by Social Security Administration, in a demonstration project relating to the terminally ill then being conducted within the Department of Health and Human Services, the purpose of such participation to be to study impact on terminally ill of provisions of disability programs administered by Social Security Administration and to determine how best to provide services needed by persons who were terminally ill through programs over which the Social Security Administration had administrative responsibility, and authorized to be appropriated necessary sums not in excess of $2,000,000 for any fiscal year.

REPORT TO CONGRESS WITH RESPECT TO RURAL OR URBAN COMPREHENSIVE MENTAL, HEALTH CENTERS AND CENTERS FOR TREATMENT OF ALCOHOLISM AND DRUG ABUSE; SUBMISSION NO LATER THAN JUNE 13, 1978


STUDY AND REVIEW BY COMPTROLLER GENERAL OF ADMINISTRATIVE STRUCTURE FOR PROCESSING MEDICARE CLAIMS; REPORT TO CONGRESS

Pub. L. 95–142, § 12, Oct. 25, 1977, 91 Stat. 1197, directed Comptroller General to conduct a comprehensive study and review of administrative structure established for processing of claims under this subchapter for purpose of determining whether and to what extent more efficient claims administration under this subchapter could be achieved and directed Comptroller General to submit to Congress no later than July 1, 1979, a complete report with respect to such study and review.

REPORT BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON DELIVERY OF HOME HEALTH AND OTHER IN-HOME SERVICES; CONTENTS; CONSULTATION REQUIREMENTS; SUBMISSION TO CONGRESS

Pub. L. 95–142, § 18, Oct. 25, 1977, 91 Stat. 1202, directed Secretary of Health, Education, and Welfare, not later than one year after Oct. 25, 1977, to submit to appropriate committees of Congress a report analyzing, evaluating, and making recommendations with respect to all aspects of delivery of home health and other in-home services authorized to be provided under subchapters XVIII, XIX, and XX of this chapter.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in title 45 section 231f.

§ 1395mm. Payments to health maintenance organizations and competitive medical plans

(a) Rates and adjustments

(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B of this subchapter only.

For purposes of this section, the term “risk-sharing contract” means a contract entered into under subsection (g) of this section and the term “reasonable cost reimbursement contract” means a contract entered into under subsection (h) of this section.

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2) of this section, to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual’s employer or former employer (or the employer or former employer of the individual’s spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided...
the individual with the explanation described in subsection (c)(3)(E) of this section at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (b)(2) of this section rather than paragraph (1).

(3) Subject to subsections (c)(2)(B)(ii) and (c)(7) of this section, payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1395f(b) and 1395l(a) of this title, for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term “adjusted average per capita cost” means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B of this subchapter, or part B only, and types of expenses otherwise reimbursable under parts A and B of this subchapter, or part B only (including administrative costs incurred by organizations described in sections 1395h and 1395a of this title), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1395x(g)(2)(H) of this title, if the services were to be furnished by a physician or as an incident to a physician’s service.

The remainder of that payment shall be paid by the former trust fund.

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan’s most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

(b) Definitions; requirements

For purposes of this section, the term “eligible organization” means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 300e-9(d)(1) of this title), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians’ services performed by physicians (as defined in section 1395x(r)(1) of this title).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians’ services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or on a group practice or individual practice basis.

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

1 See References in Text note below.
Paragraph (2)(A)(ii) shall not apply to a contract under this section until the first contract year that begins after the end of such period; and

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) of this section shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days during every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) of this section in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) of this section or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(ii)(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enroll-

*So in original. Probably should be "significant".*
ment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual’s termination of enrollment, the organization shall provide the individual with a copy of the written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization unless (i) at least 45 days before its distribution, the organization submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary’s discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual’s health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual’s enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee’s rights under this section, including an explanation of—

(i) the enrollee’s rights to benefits from the organization,
(ii) the restrictions on payments under this subchapter for services furnished other than by or through the organization,
(iii) out-of-area coverage provided by the organization,
(iv) the organization’s coverage of emergency services and urgently needed care, and
(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this subchapter related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this subchapter, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in—

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must—

(A) make the services described in paragraph (2) and (such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be enti-
tied to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this sub-paragraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this subchapter as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1395ww(d) of this title, and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(d) Right to enroll with contracting organization in geographic area

Subject to the provisions of subsection (c)(3) of this section, every individual entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter or enrolled under part B of this subchapter only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e) Limitation on charges; election of coverage; "adjusted community rate" defined; workmen's compensation and insurance benefits

(1) In no case may—

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B of this subchapter) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B of this subchapter) to individuals who are enrolled under this section with the organization and enrolled under part B of this subchapter only exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, or enrolled under part B only, respectively, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this subchapter, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2) of this section) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service or services means, at the election of an eligible organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a "community rating system" (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or
(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen’s compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—
(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f) Membership requirements

(1) For contract periods beginning before January 1, 1999, each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this subchapter.

(2) Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—
(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter, or
(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

(g) Risk-sharing contract

(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b) of this section, which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—
(A) if the adjusted community rate, as defined in subsection (e)(3) of this section, for services under parts A and B of this subchapter (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or
(B) if the adjusted community rate for services under part B of this subchapter (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B of this subchapter only
is less than the average of the per capita rates of payment to be made under subsection (a)(1) of this section at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or enrolled in part B of this subchapter only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A of this subchapter and enrolled in part B of this subchapter, or enrolled in part B of this subchapter only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5).

If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates
of payment to be made under subsection (a)(1) of this section at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

The additional benefits referred to in paragraph (2) are—

(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.


(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary’s payments (and costs incurred by the Secretary in making such payments).

(h) Reasonable cost reimbursement contract; requirements

(1) If—

(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1) of this section, the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1395x(v) of this title) in the manner prescribed in paragraph (3).

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1395x(v) of this title) or for payment amounts determined in accordance with section 1395ww of this title, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d) of this section, and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1395x(v) of this title) or the amount determined under section 1395ww of this title, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1395ww of this title for the types of expenses otherwise reimbursable under this subchapter for providing services covered under this subchapter to individuals described in subsection (a)(1) of this section.

(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this subchapter for providing services described in subsection (a)(1) of this section, including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which an eligible organization is related to another organization...
by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this subchapter, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(5)(A) After August 5, 1997, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of August 5, 1997), except for a contract with an eligible organization which, immediately previous to entering into such contract, had an agreement in effect under section 1395(a)(1)(A) of this title.

(B) The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2004.

(i) Duration, termination, effective date, and terms of contract; powers and duties of Secretary

(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f) of this section.

(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(3) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled under this section with the organization;

and

(C)(i) shall require the organization to comply with subsections (a) and (c) of section 300e-17 of this title (relating to disclosure of certain financial information) and with the requirement of section 300e(c)(8) of this title (relating to liability arrangements to protect members);

(ii) shall require the organization to provide and supply information (described in section 1395cc(b)(2)(C)(ii) of this title) in the manner such information is required to be provided or supplied under that section;

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of den-

\footnote{See References in Text note below.}
(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and, plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice in violation of such subparagraph, of not more than $25,000 for each determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization’s contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain a written agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1320c–3(a)(4)(C) of this title under which the review organization will perform functions under section 1320c–3(a)(4)(B) of this title and section 1320c–3(a)(14) of this title (other than those performed under contracts described in section 1395ccc(a)(1)(F) of this title) with respect to services, furnished by the eligible organization, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this subchapter and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations’ conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of subchapter XI of this chapter.

(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided
with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) In this paragraph, the term "physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary’s determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization’s attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

(j) Payment in full and limitation on actual charges; physicians, providers of services, or renal dialysis facilities not under contract with organization

(1)(A) In the case of physicians’ services or renal dialysis services described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with an eligible organization under this section and enrolled under part B of this subchapter, the applicable participation agreement is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B of this subchapter and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians’ services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B of this subchapter (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians’ services or renal dialysis services described in this paragraph are physicians’ services or renal dialysis services which are furnished to an enrollee of an eligible organization under this section by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.

(k) Risk-sharing contracts

(1) Except as provided in paragraph (2)—

(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1395w–26(b)(1) of this title, the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization under this section.

(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

(2) An individual who is enrolled in part B of this subchapter only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1395w–26(b)(1) of this title.

(3) Notwithstanding subsection (a) of this section, the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B of this subchapter, by substituting payment rates under section 1395w–23(a) of this title for the payment rates otherwise established under subsection (a) of this section, and

(B) with respect to individuals only entitled to benefits under part B of this subchapter, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this subchapter attributable to such part) for the payment rates otherwise established under subsection (a) of this section.

*So in original. Probably should be "section".
(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C of this subchapter:

(A) Data collection requirements under section 1395w–23(a)(3)(B) of this title.

(B) Restrictions on imposition of premium taxes under section 1395w–24(g) of this title in relating to payments to such organizations under this section.

(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1395w–21(e)(6) of this title.

(D) Payments under section 1395w–27(e)(2) of this title.


References in Text

Parts A and B of this subchapter, referred to in text, are classified to sections 1395c et seq. and 1985 (3) et seq., respectively, of this title.

Section 300e–9(d) of this title, referred to in subsec. (b)(1), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, § 5(b), Oct. 24, 1988, 102 Stat. 2579.

Part C of this subchapter, referred to in subsec. (k)(4), is classified to section 1395w–21 et seq. of this title.

Amendments


1997—Subsec. (j)(1). Pub. L. 106–33, § 4002(a)(1), substituted “For contract periods beginning before January 1, 1999, each” for “Each” and struck out “or under a State plan approved under subchapter XIX of this chapter” before period at end.

_subsec. (f)(2). Pub. L. 105–33, § 4002(a)(2), substituted “Subject to paragraph (4), the Secretary” for “The Secretary”.


1996—Subsec. (j)(1). Pub. L. 104–191, § 215(a)(1), substituted “in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the interim immediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—” for “the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—” in introductory provisions, added subpars. (A) to (C), and struck out former subpars. (A) to (C) which read as follows: “(A) has failed substantially to carry out the contract, “(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or “(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f) of this section.”

Subsec. (i)(6)(B). Pub. L. 104–191, § 215(a)(4), struck out concluding provisions which read as follows: “The provisions of section 1520a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1520a–7a of this title.”


Subsec. (i)(7)(A). Pub. L. 104–191, § 215(b), substituted “a written agreement” for “an agreement”.


Subsec. (c)(3). Pub. L. 103–432, § 157(b)(1), substituted “subsection (c)(2) of subsection (B) of this section” for “subsection (c)(7)” of this section.

Subsec. (c)(5)(B). Pub. L. 103–296 inserted at end “In applying sections 405(b) and 486(g) of this title as provided in this subparagraph, and in applying section 405(e) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.”


Subsec. (a)(6). Pub. L. 101–508, § 4204(c)(2), substituted “subsections (c)(2)(B)(ii) and (c)(7)” for “subsection (c)(7)”.

Subsec. (c)(2). Pub. L. 101–508, § 4204(c)(1), designated existing provisions as subpar. (A), redesignated former subpar. (A) and former cls. (i) and (ii) as cls.
(1) and (ii) and subcl. (I) and (II), respectively, and added subpar. (H).


Subsec. (j)(1)(A). Pub. L. 101–508, § 4204(d)(1)(A), substituted “physicians’ services or renal dialysis services” for “physicians’ services,” “physician or provider of services or renal dialysis facility” for “physician” in three places, and “applicable participation agreement for “participation agreement under section 1396u(b)(1) of this title”.

Subsec. (j)(2). Pub. L. 101–508, § 4204(d)(1)(B), substituted “physicians’ services or renal dialysis services” for “physicians’ services” in two places and “which are furnished to an enrollee of an eligible organization under this section [sic] by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.” for “which—” and subpars. (A) and (B) which read as follows:

“(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A) of this section), and

“(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.”


Subsec. (a)(5). Pub. L. 101–234, § 202(a), repealed Pub. L. 100–360, § 211(c)(3)(A), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1989 Amendment note below.


Subsec. (c)(3)(A)(ii). Pub. L. 101–239, § 6206(b)(1)(B), added (ii) and struck out former cl. (i) which read as follows: “For each area served by more than one eligible organization under this section, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which all eligible organizations serving the area must provide for open enrollment under this section. The Secretary shall determine annual per capita rates under subsection (a)(1)(A) of this section in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased for 12 months beginning on the date the individual’s enrollment becomes effective. An eligible organization may provide for such other enrollment period or periods as it deems appropriate consistent with this section.”

Subsecs. (e)(1), (g)(3)(A). Pub. L. 101–234, § 201(a), repealed Pub. L. 100–360, § 2102(f), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.


1988—Subsec. (a)(5). Pub. L. 100–360, § 211(c)(3)(B), amended second sentence generally. Prior to amendment, second sentence read as follows: “The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1395r(a)(4) of this title; and

(B) the product of (i) the number of such individuals for the month who have not attained age 65, and
(other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under this section unless at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and the Secretary has not disapproved the distribution of the material, and that Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary’s discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.


Subsec. (f)(2). Pub. L. 99–509, § 9312(c)(1), struck out “if the Secretary determines that” after “imposed by paragraph (1) only”, added new subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows: “(A) special circumstances warrant such modification or waiver, and “(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter.”


Subsec. (i)(1)(C). Pub. L. 99–509, § 9312(c)(3)(B), substituted “(e), and (f)” for “(e)”.

Subsec. (i)(3)(C). Pub. L. 99–509, § 9312(e)(1), designated existing provisions as cl. (i) and added cl. (ii) and (iii).


Subsec. (c)(3)(A). Pub. L. 98–369, § 2350(a)(1), designated existing provisions as cl. (i), inserted “and including the 30-day period specified under clause (ii)” after “30 days duration every year”, and added cl. (ii).


Subsec. (g)(2). Pub. 98–369, § 2350(b)(1), inserted “and except that an organization (with the approval of the Secretary) may provide that the part of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5)” at end of first sentence.

Subsec. (g)(4)(A). Pub. L. 98–369, § 2350(c), inserted “or skilled nursing facilities” after “hospitals”, inserted “or the appropriate basis for payment established under this subchapter” after “(paragraph (1) of section 1395x(v) of this title), and struck out “hospital” before “services furnished to individuals”.


Subsec. (g)(1). Pub. L. 97–248 substituted “subparagraph (b)” for “subparagraph (b)(1)”.

Subsec. (g)(4). Pub. L. 98–21, § 602(g), added par. (4).

1962—Pub. L. 97–248 completely revised section, expanding its coverage to permit payments to both health maintenance organizations and competitive medical plans.


1976—Subsec. (b). Pub. L. 94–460 substituted “the Secretary” for “the Commissioner of Social Security”.

1975—Subsec. (a)(6). Pub. L. 94–460, § 602(a)(a), substituted “30 days” for “90 days”.


1972—Subsec. (a)(6). Pub. L. 92–603 increased the 30 days period of clause (i) to 60 days, and substituted “45 days” for “30 days”.

1971—Subsec. (a)(6). Pub. L. 91–226 increased the 30 days period to 45 days.

1969—Subsec. (a)(6). Pub. L. 91–284 substituted “30 days” for “50 days”.

1967—Subsec. (a)(6). Pub. L. 90–248 increased the 30 days period to 60 days.

1965—Subsec. (a)(6). Pub. L. 89–250 increased the 30 days period to 90 days.

1960—Subsec. (a)(6). Pub. L. 86–269 increased the 30 days period to 45 days.

1959—Subsec. (a)(6). Pub. L. 86–269 increased the 30 days period to 30 days.

1958—Subsec. (a)(6). Pub. L. 85–425 increased the 30 days period to 90 days.

1957—Subsec. (a)(6). Pub. L. 85–50 increased the 30 days period to 45 days.

1956—Subsec. (a)(6). Pub. L. 84–88 increased the 30 days period to 30 days.

1955—Subsec. (a)(6). Pub. L. 84–127 increased the 30 days period to 60 days.

1954—Subsec. (a)(6). Pub. L. 83–408 increased the 30 days period to 45 days.
access to qualified practitioners in specialties available in area served by such organization, demonstrates financial responsibility and means to provide comprehensive health care services, has at least half of its enrolled members under age 65, assures prompt and qualified health service, and has an open enrollment period at least every year, and revised the definition and requirements of an health maintenance organization to conform to those set forth in the Public Health Service Act, except that the services which such an organization must provide are those covered in parts A and B of this subchapter rather than the basic health services defined in the Public Health Service Act, and inserted provisions requiring Secretary to administer determinations of whether an organization is a health maintenance organization through and in the office of the Assistant Secretary for Health, to integrate the administration of such functions and duties with the administration of provisions requiring the continued regulation of health maintenance organizations under the Public Health Service Act, and to administer other provisions of this section through the Commissioner of Social Security.

Subsec. (b). Pub. L. 94–469, § 201(b), substituted provisions that each health maintenance organization with which the Secretary enters into a contract under this section have an enrolled membership at least half of which consists of individuals who have not attained age 65, with the Secretary empowered to waive that requirement for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i) of this section for provisions that such requirement not apply with respect to any health maintenance organization for such period not to exceed three years from the date such organization enters into an agreement with the Secretary pursuant to subsection (i) of this section, as the Secretary might permit.

Subsec. (i)(6)(B). Pub. L. 94–469, § 201(c), substituted “other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year” for “(Other than those with respect to out-of-area services)”.

Subsec. (k). Pub. L. 94–469, § 201(d), added subsec. (k). 1973—Subsec. (a)(3)(A)(i). Pub. L. 93–233, § 1(i)(m), struck out “, with the apportionment of savings being proportional to the losses absorbed and not yet offset” at end. Subsec. (g)(2). Pub. L. 93–233, § 1(i)(m), substituted “port of its premium rate or other charges” for “portion” and “shall not exceed” for “may not exceed”, and struck out (i) designation preceding “the actuarial value” and provisions reading “less (ii) the actuarial value of other charges made in lieu of such deductible and coinsurance”, respectively.


§ 1395mm TITLE 42—THE PUBLIC HEALTH AND WELFARE

Amendment by section 202(f) of Pub. L. 100–360 applicable to enrollments effected on or after Jan. 1, 1990, see section 202(m)(3) of Pub. L. 100–360, set out as a note under section 1395t of this title.

Amendment by section 211(c)(3) of Pub. L. 100–360 applicable, except as specified in such amendment, to monthly premiums for months beginning with January 1989, see section 211(d) of Pub. L. 100–360, set out as a note under section 1395t of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(1), (3), (4), (6), (e)(3) of Pub. L. 100–360, as it relates to a provision in Pub. L. 100–360, amendment by section 411(c)(1), (3), (4), (6), effective as if included in the enactment of that provision in Pub. L. 100–360, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date of this title.

Effective Date of 1987 Amendment

Section 4011(a)(2) of Pub. L. 100–203 provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987]."

Section 4011(b)(2) of Pub. L. 100–203 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 22, 1987]."

Section 4012(d) of Pub. L. 100–203 provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395cc of this title] shall apply to admissions occurring on or after April 1, 1988, or, if later, the earliest date the Secretary can provide the information required under subsection (c) [set out as a note below] in machine readable form."

Section 4013(b) of Pub. L. 100–203, which provided the effective date for amendment made by section 4013(a) of Pub. L. 100–203, was omitted in the general amendment of section 4013 of Pub. L. 100–203 by Pub. L. 100–360, title IV, §411(c)(3), July 1, 1988, 102 Stat. 773.

Effective Date of 1986 Amendments

Section 1905(b)(1)(B) of Pub. L. 99–514 provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to determinations of per capita payment rates for 1987 and subsequent years."


"(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act."

"(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that:"

"(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act [subsec. (f)(2) of this section], a modification or waiver of the requirement imposed by paragraph (1) of that section, but

"(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection, the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for the sanction described in section 1876(f)(3) of the Social Security Act [subsec. (f)(3) of this section] (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance."

"(D) TREATMENT OF CERTAIN WAIVERS.—In the case of an eligible organization (or successor organization) that is described in clauses (i) and (ii) of subparagraph (C) and that received a grant or grants totaling at least $3,000,000 in fiscal year 1987 under section 526(e)(1)(A) or 530(d)(1) of the Public Health Service Act [42 U.S.C. 294b(d)(1)(A), 254(c)(d)(1)]—"

"(i) before January 1, 1996, section 1876(f) of the Social Security Act [subsec. (f) of this section] shall not apply to the organization;"

"(ii) beginning on January 1, 1996, the Secretary of Health and Human Services shall conduct an annual review of the organization to determine the organization’s compliance with the quality assurance requirements of section 1876(c)(6) of such Act [subsec. (c)(6) of this section]; and

"(iii) after January 1, 1996, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act [subsec. (f)(3) of this section] effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act."

Section 9312(d)(2) of Pub. L. 100–203 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to risk-sharing contracts under section 1876 of the Social Security Act [this section] with respect to services furnished on or after January 1, 1987."

Section 9312(e)(2) of Pub. L. 99–509 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to contracts as of January 1, 1987."

Section 9333(e)(3)(B) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, §4093(a)(10), as added by Pub. L. 100–360, title IV, §411(c)(3), July 1, 1988, 102 Stat. 776, provided that: "The amendment made by paragraph (2) [amending this section] shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act [this section], as of April 1, 1987. The provisions of section 1876(f)(7) of the Social Security Act [subsec. (f)(7) of this section] (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97–248 [Sept. 3, 1982]) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act [Dec. 22, 1987])."

Section 9211(e) of Pub. L. 99–272 provided that:

"(1) FINANCIAL RESPONSIBILITY.—The amendments made by subsection (a) [amending this section] shall apply to enrollments and disenrollments that become effective on or after the date of the enactment of this Act [Apr. 7, 1986]."

"(2) DISENROLLMENTS.—The amendments made by subsection (b) [amending this section] shall apply to requests for termination of enrollment submitted on or after May 1, 1986.

"(3) MATERIAL REVIEW.—(A) The amendment made by subsection (c) [amending this section] shall not apply to material which has been distributed before July 1, 1986.
“(B) Such amendment also shall not apply so as to re-
quire the submission of material which is distributed
before July 1, 1986.
“(C) Such amendment shall also not apply to ma-
terial which the Secretary determines has been prepared
before the date of the enactment of this Act [Apr. 7, 
1986] and for which a commitment for distribution has
been made, if the application of such amendment would
constitute a hardship for the organization involved.
“(4) Publication.—The amendment made by sub-
section (d) [amending this section] shall apply to deter-
minations of per capita rates of payment for 1987 and
subsequent years.
“(5) Necessary Modification of Contracts.—The
Secretary of Health and Human Services shall provide
for such changes in the contracts which have
been entered into under section 1876 of the Social
Security Act [this section] as may be necessary to con-
form to the requirements imposed by the amendments
made by this section [amending this section] on a time-
ly basis.”

Effective Date of 1984 Amendment

Section 2350(d) of Pub. L. 98–369 provided that: ‘‘The amendments made by this section [amending this section
and enacting provisions set out as notes under this
subchapter] shall become effective on the date of the enact-
ment of this Act [July 18, 1984].’’

Amendment by section 2354(b)(37), (38) of Pub. L.
98–369 effective July 18, 1984, but not to be construed as
changing or affecting any right, liability, status, or in-
terpretation 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.

Effective Date of 1983 Amendments: Transitional
Rule

Amendment by section 603(g) of Pub. L. 98–21 applicable
to items and services furnished by or under arrange-
ments with organizations furnishing care under 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 section 606(a)(3)(B) of Pub. L. 98–21 applicable
to premiums for months beginning with January
1984, but for months after June 1983 and before
January 1984, the monthly premium for June 1983 shall
apply to individuals enrolled under parts A and B of
this subchapter, see section 606(c) of Pub. L. 98–21, set
out as a note under section 1395ww of this title.

Amendment by section 308(b)(12) of Pub. L. 97–448 ef-
forced 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
308(c)(2) of Pub. L. 97–448, set out as a note under
section 4201 of this title.

Effective Date of 1982 Amendment

Section 114(c) of Pub. L. 97–248, as amended by Pub.
L. 98–369, div. B, title III, §2354(c)(9)(A), (B), July 18,
1984, 98 Stat. 1192; Pub. L. 98–417, §3(a)(5), Nov. 8, 1984,
98 Stat. 3295; Pub. L. 99–509, title IX, §9312(a), Oct. 21,
1986, 100 Stat. 1969, provided that:
“(1) Subject to paragraph (2), the amendment made
by subsection (a) [amending this section] shall apply
with respect to services furnished on or after the initial
effective date (as defined in paragraph (4)), except that
such amendment shall not apply—
“(A) with respect to services furnished by an eligi-
ble organization to any individual who is enrolled
with that organization under an existing cost con-
tact (as defined in paragraph (3)(D)) unless—
“(i) the individual requests at any time that the
amendment apply, or
“(ii) the Secretary determines at any time that
the amendment should apply to all members of the
organization because of administrative costs or
other administrative burdens involved and so
forms in advance each affected member of the eligi-
ble organization;
“(B) with respect to services furnished by an eligi-
ble organization during the five-year period begin-
ning on the initial effective date, if—
“(i) the organization has an existing risk-sharing
contract (as defined in paragraph (3)(B)) on the ini-
tial effective date, or
“(ii) on the date of the enactment of this Act
[Sept. 3, 1982] the organization was furnishing serv-
ces pursuant to an existing demonstration project
(as defined in paragraph (3)(C)), such demonstration
project is concluded before the initial effective
date, and before such initial effective date the orga-
nization enters into an existing risk-sharing con-
tact, unless the organization requests that the amendment
apply earlier; or
“(C) with respect to services furnished by an eligi-
bile organization during the period of an existing dem-
stration project if on the initial effective date the
organization was furnishing services pursuant to the
project and if the project concludes after such date.
“(2)(A) In the case of an eligible organization which
has in effect an existing cost contract (as defined in
paragraph (3)(A)) on the initial effective date, the orga-
nization may receive payment under a new risk-sharing
contract with respect to a current, nonrisk medicare
enrollee (as defined in subparagraph (C)) only to the ex-
tent that the organization enrolls, for each such en-
rrollee, two new medicare enrollees (as defined in sub-
paragraph (D)). The selection of those current nonrisk
medicare enrollees with respect to whom payment may
be so received under a new risk-sharing contract shall
be made in a nonbiased manner.
“(B) Subparagraph (A) shall not be construed to pre-
vent an eligible organization from providing for enroll-
ment, on a basis described in subsection (a)(6) of sec-
tion 1876 of the Social Security Act [subsection (g)(2) of
this section] (as amended by this Act [Pub. L. 97–248],
other than under a reasonable cost reimbursement con-
tact), of current, nonrisk medicare enrollees and from
providing such enrollees with some or all of the addi-
tional benefits described in section 1876(g)(2) of the
Social Security Act [subsection (g)(2) of this section] (as
amended by this Act [Pub. L. 97–248]), but (except as
provided in subparagraph (A))—
“(i) payment to the organization with respect to
such enrollees shall only be made in accordance with
the terms of a reasonable cost reimbursement con-
tact, and
“(ii) no payment may be made under section 1876 of
such Act [this section] with respect to such enrollees
for any such additional benefits.

Individuals enrolled with the organization under this
subparagraph shall be considered to be individuals en-
rrolled with the organization for the purpose of meeting
the requirement of section 1876(g)(2) of the Social
Security Act [subsection (g)(2) of this section] (as
amended by this Act [Pub. L. 97–248]).
“(C) For purposes of this paragraph, the term ‘cur-
rent, nonrisk medicare enrollee’ means, with respect to
an organization, an individual who on the initial effec-
tive date—
“(1) is enrolled with that organization under an ex-
isting cost contract, and
“(2) is entitled to benefits under part A and en-
rrolled under part B, or enrolled in part B, of title
XVIII of the Social Security Act [this subchapter].
“(D) For purposes of this paragraph, the term ‘new
medicare enrollee’ means, with respect to an organiza-
tion, an individual who—
“(i) is enrolled with the organization after the date the organization first enters into a new risk-sharing contract.

(II) at the time of such enrollment is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act [this subchapter], and

(III) was not enrolled with the organization at the time the individual became entitled to benefits under part A, or to enroll in part B, of such title [this subchapter].

(E) The preceding provisions of this paragraph shall not to [sic] apply to payments made for current, nonrisk Medicare enrollees for months beginning with April 1987.

(F) For purposes of this subsection:

‘‘(A) The term ‘existing cost contract’ means a contract which is entered into under section 1876 of the Social Security Act [this section], as in effect before the initial effective date, or reimbursement on a reasonable cost basis under section 1395a(i)(1)(A) of such Act [section 1395a(a)(1)(A) of this title], and which is not an existing risk-sharing contract or an existing demonstration project.

‘‘(B) The term ‘existing risk-sharing contract’ means a contract entered into under section 1876(i)(2)(A) of the Social Security Act [subsec. (i)(2)(A) of this section], as in effect before the initial effective date.

‘‘(C) The term ‘existing demonstration project’ means a demonstration project under section 402(a) of the Social Security Amendments of 1967 [section 1395b–1(a)(1) of this title] or under section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92–603, set out as a note under section 1395b–1 of this title], relating to the provision of services for which payment may be made under title XVIII of the Social Security Act [this subchapter].

‘‘(D) The term ‘new risk-sharing contract’ means a contract entered into under section 1876(g) of the Social Security Act [subsec. (g) of this section], as amended by this Act [Pub. L. 97–248].

‘‘(E) The term ‘reasonable cost reimbursement contract’ means a contract entered into under section 1876(b) of such Act [subsec. (b) of this section], as amended by this Act, or reimbursement on a reasonable cost basis under section 1395a(i)(1)(A) of such Act [section 1395a(a)(1)(A) of this title].

‘‘(F) As used in this section, the term ‘initial effective date’ means—

(A) the first day of the thirteenth month which begins after the date of the enactment of this Act [Sept. 3, 1982], or

(B) for the first day of the first month [Feb. 1, 1985] after the month in which the Secretary of Health and Human Services notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives that he is reasonably certain that the methodology to make appropriate adjustments (referred to in section 1876(a)(4) of the Social Security Act [subsec. (a)(4) of this section], as amended by this Act [Pub. L. 97–248]) has been developed and can be implemented to assure actuarial equivalence in the estimation of adjusted average per capita costs under that section, whichever is later.’’

Effective Date of 1976 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 1976 Amendment

Section 201(e) of Pub. L. 94–460 provided that: ‘‘The amendments made by this section [amending this section] shall be effective with respect to contracts entered into between the Secretary and health maintenance organizations under section 1876 of the Social Security Act [this section] on and after the first day of the first calendar month which begins more than 30 days after the date of enactment of this Act [Oct. 8, 1976].’’

Effective Date of 1973 Amendment

Section 18(z–3)(d) of Pub. L. 93–233 provided that: ‘‘The amendments made by subsections (m) and (n) [amending this section] shall be effective with respect to services provided after June 30, 1973.’’

Effective Date

Section 229(f) of Pub. L. 92–603 provided that: ‘‘The amendments made by this section [enacting this section, amending sections 1395i, 1395l, 1396i, and 1396b of this title, and enacting provisions set out under this section] shall be effective with respect to services provided on or after July 1, 1973.’’

Report on Impact

Section 4002(b)(2)(B) of Pub. L. 105–33 provided that: ‘‘By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that analyzes the potential impact of termination of reasonable cost reimbursement contracts, pursuant to the amendment made by subparagraph (A), on Medicare beneficiaries enrolled under such contracts and on the Medicare program. The report shall include such recommendations regarding any extension or transition with respect to such contracts as the Secretary deems appropriate.’’

Transition Rule for PFS Enrollment

Section 4002(h) of Pub. L. 105–33 provided that: ‘‘In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395 impair to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855d(1) of such Act [section 1395w–25d(1) of this title], as inserted by section 5001 [4001] for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1876(i)(1) of such Act [1395w–27(b)(1) of this title] (as so inserted).’’

Requirements With Respect to Actuarial Equivalence of AAPPCC


‘‘(1)(A) Not later than October 1, 1995, the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1997 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act [subsec. (g) of this section].

‘‘(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

(i) the difference in costs associated with Medicare beneficiaries with differing health status and demographic characteristics; and

(ii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

‘‘(2) Not later than 3 months after the date of submission of the proposal under paragraph (1), the Comptroller
General shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications.

Section 220(f) of Pub. L. 101–508, as amended by Pub. L. 106–422, title I, § 1157(b)(6), Oct. 31, 1994, 108 Stat. 4442, directed Secretary to conduct a study of the extent to which health maintenance organizations with contracts under section 1876 of the Social Security Act (this section) make available to enrollees entitled to benefits under title XVIII of such Act (this subchapter) chiropractic services that are covered under such title, such study to examine the arrangements under which such services are made available and the types of practitioners furnishing such services to such enrollees and to be based on contracts entered into or renewed on or after Jan. 1, 1991, and before Jan. 1, 1993, with Secretary to issue a report to Congress on results of the study not later than Jan. 1, 1993, including recommendations with respect to any legislative and regulatory changes determined necessary by Secretary to ensure access to such services.

Effect of State Law

Conscientious objections of health care provider under State law unaffected by enactment of subsections (c)(8) of this section, see section 220(c) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

Notice of Methodology Used in Making Announcements Under Subsection (a)(1)(A)

Section 220(a)(2) of Pub. L. 101–239 provided that: "Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act [subsec. (a)(1)(A) of this section] for 1990."

Adjustment of Contracts With Prepaid Health Plans

Section 203(b) of Pub. L. 101–234 provided that: "Notwithstanding any other provision of this Act [see Tables for classification], the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act [sections 1395cc(c)(5) and 1395cc(c)(6) of this title]) shall not apply to risk-sharing contracts, for contract year 1990—

"(1) with eligible organizations under section 1876 of the Social Security Act [this section], or

"(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act [subsec. (i)(2)(A) of this section] (as in effect before February 1, 1985), under section 4012(c) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, § 411(c)(2)(B), July 1, 1988, 102 Stat. 773, provided that: "The Secretary of Health and Human Services shall provide (in machine readable form) to eligible organizations under section 1876 of the Social Security Act [this section] medicare DRG rates for payments required by the amendment made by subsection (a) [amending section 1395cc of this title] and on data cost pass-through items for all inpatient services provided to medicare beneficiaries enrolled with such organizations."

Medicare Payment Demonstration Projects


"(a) Medicare Insured Group Demonstration Projects.—

"(1) The Secretary of Health and Human Services shall provide for capitation demonstration projects (in this subsection referred to as 'projects') with an entity which is an eligible organization with a contract with the Secretary under section 1876 of the Social Security Act [this section] or which meets the requirements of this subsection. The Secretary may not approve a project unless it meets the requirements of this subsection.

"(2) The Secretary may not conduct more than 3 projects and may not expend, from funds under title XVIII of the Social Security Act [this subchapter], more than $600,000,000 in any fiscal year for all such projects.

"(3) The per capita rate of payment under a project—

"(A) may be based on the adjusted average per capita cost (as defined in section 1876(a)(4) of the Social Security Act [subsec. (a)(4) of this section]) determined only with respect to the group of individuals involved (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

"(B) the rate of payment may not exceed the lesser of—

"(i) 95 percent of the adjusted average per capita cost described in subparagraph (A), or

"(ii)(I) in the 4th year or 5th year of a project, 115 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) of such Act [subsec. (a)(4) of this section]) for classes of individuals described in section 1876(a)(1)(B) of that Act [subsec. (a)(1)(B) of this section]; or

"(II) in any subsequent year of a project, 95 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) [subsec. (a)(4) of this section]) for such classes.

"(4) If the payment amounts made to a project are greater than the costs of the project (as determined...
by the Secretary or, if applicable, on the basis of adjusted community rates described in section 1876(e)(3) of the Social Security Act [subsec. (e)(3) of this section] or the project—

(A) may retain the surplus, but not to exceed 5 percent of the average adjusted per capita cost determined in accordance with paragraph (3)(A), and shall apply such surplus to any additional surplus not retained by the project, shall apply such surplus to additional benefits for individuals served by the project or return such surplus to the Secretary.

(3) The Secretary shall approve the project only if, with respect to any additional surplus not retained by the Secretary or, if applicable, on the basis of activities served, the Secretary (in this subsection referred to as the 'Secretary') is specifically authorized to conduct demonstration projects under this subsection for the purpose of testing alternative payment methodologies pertaining to capitation payments under title XVIII of the Social Security Act [this subchapter], including—

(A) computing adjustments to the average per capita cost under section 1876 of such Act [this section] on the basis of health status or prior utilization of services, and

(B) accounting for geographic variations in cost in the adjusted average per capita costs attributable to an eligible organization under such section which differs from payments currently provided on a county-by-county basis.

(2) No project may be conducted under this subsection—

(A) with an entity which is not an eligible organization (as defined in section 1876(b) of the Social Security Act [subsec. (b) of this section]), and

(B) unless the project meets all the requirements of subsections (c) and (i)(3) of section 1876 of such Act [subsecs. (c) and (i)(3) of this section].

(3) There are authorized to be appropriated to carry out projects under this subsection $5,000,000 in each of fiscal years 1989 and 1990.

(c) Application of Provisions.—The provisions of subsection (a)(2) and the first sentence of subsection (b) of section 402 of the Social Security Amendments of 1967 [section 1395b–1(a)(2), (b) of this title] shall apply to the demonstration projects under this section in the same manner as they apply to experiments under subsection (a)(1) of that section.

GAO Study and Reports on Medicare Capitation

Section 4017 of Pub. L. 105–203 directed Comptroller General to conduct a study on medicare capitation rates that would include an analysis and assessment of the current method for computing per capita rates of payment under section 1876 of the Social Security Act (this section), including the method for determining the United States per capita cost; the method for establishing relative costs for geographic areas and the data used to establish age, sex, and other weighting factors; ways to refine the calculation of adjusted average per capita costs under section 1876 of such Act, including making adjustments for health status or prior utilization of services and improvements in the definition of geographic areas; the extent to which individuals enrolled with organizations with a risk-sharing contract with the Secretary under section 1876 of such Act differ in utilization and cost from fee-for-service beneficiaries and ways for modifying enrollment patterns through program changes or for reflecting the differences in rates through group experience rating or other means; approaches for limiting the liability of the contracting organization under section 1876 of such Act in catastrophic cases; ways of establishing capitation rates on a basis other than fee-for-service experience in areas with high prepaid market penetration; and methods for providing the rate levels necessary to maintain access to quality prepaid services in rural or medically underserved areas, while maintaining cost savings; and directed Comptroller General, not later than July 1 of 1989 and 1990, to submit to Congress interim reports on the progress of the study and, not later than Jan. 1, 1991, a final report on the results of such study.

Demonstration Projects To Provide Payment on a Prepaid, Capitated Basis for Community Nursing and Ambulatory Care Furnished to Medicare Beneficiaries

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 532], Nov. 29, 1999, 113 Stat. 1536, 1501A–388, provided that:

(a) Extension.—Notwithstanding any other provision of law, any demonstration project conducted under section 4019 of the Omnibus Budget Reconciliation Act of 1987 [Public Law 100–123 [Pub. L. 100–203]; 42 U.S.C. 1395mm note] and conducted for the additional period of 2 years as provided for under section 4019 of BBA [Pub. L. 105–33, set out as a note below], shall be conducted for an additional period of 2 years. The Secretary of Health and Human Services shall provide for such reduction in payments under such project in the extension period provided under the previous sentence as the Secretary determines is necessary to ensure that total Federal expenditures during the extension period
under the project do not exceed the total Federal expenditures that would have been made under title XVIII of the Social Security Act [this subchapter] if such project had not been so extended.

“(b) REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.”

Section 4019 of Pub. L. 106–33 provided that: “Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, (Pub. L. 100–203, set out as a note below) may be conducted for an additional period of 2 years and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

Section 4079 of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(h)(8), July 1, 1988, 102 Stat. 787, provided that:

“§ 1395mm. Definitions of community nursing and ambulatory care organization (in accordance with subsection (c)(2)).

“(b) Definitions of community nursing and ambulatory care organization.—As used in this section:

“(1) The term ‘community nursing and ambulatory care organization’ means an entity that:

“(A) Part-time or intermittent nursing care furnished by or under the supervision of registered professional nurses.

“(B) Physical, occupational, or speech therapy.

“(C) Social and related services supportive of a plan of ambulatory care.

“(D) Part-time or intermittent services of a home health aide.

“(E) Medical supplies (other than drugs and biologicals) and durable medical equipment while under a plan of care.

“(F) Medical and other health services described in paragraphs (2)(H)(1) and (5) through (9) of section 1395x(s)(3) of the Social Security Act [section 1395x(s)(2)(H)(1), (5)–(9) of this title].

“(G) Rural health clinic services described in section 1861(aa)(1)(C) of such Act [section 1861(aa)(1)(C) of this title].

“(H) Certain other related services listed in section 1915(c)(4)(B) of such Act [section 1915(c)(4)(B) of this title] to the extent the Secretary finds such services are appropriate to prevent the need for institutionalization of a patient.

“(2) The term ‘eligible organization’ means a public, non-profit entity, organized under the laws of any State, which meets the following requirements:

“(A) The entity (or a division or part of such entity) is primarily engaged in the direct provision of community nursing and ambulatory care.

“(B) The entity provides directly, or through arrangements with other qualified personnel, the services described in paragraph (1).

“(C) The entity provides that all nursing care (including services of home health aids) is furnished by or under the supervision of a registered nurse.

“(D) The entity provides such services of home health aids are furnished by qualified staff and are coordinated by a registered professional nurse.

“(E) The entity has policies governing the furnishing of community nursing and ambulatory care that are developed by registered professional nurses in cooperation with (as appropriate) other professionals.

“(F) The entity maintains clinical records on all patients.

“(G) The entity has protocols and procedures to assure, when appropriate, timely referral to or consultation with other health care providers or professionals.

“(H) The entity complies with applicable State and local laws governing the provision of community nursing and ambulatory care to patients.

“(I) The requirements of paragraphs (B), (D), and (E) of section 1876(b)(2) of the Social Security Act [42 U.S.C. 1395mm(b)(2); (D); (E)].

“(c) Agreements With Eligible Organizations To Conduct Demonstration Projects.—

“(1) The Secretary may not enter into an agreement with an eligible organization to conduct a demonstration project under this section unless the organization meets the requirements of this subsection and subsection (e) with respect to members enrolled with the organization under this section.

“(2) The organization shall have an open enrollment period for the enrollment of individuals under this section. The duration of such period of enrollment and any other requirement pertaining to enrollment or termination of enrollment shall be specified in the agreement with the organization.

“(3) The organization must provide to members enrolled with the organization under this section, through providers and other persons that meet the applicable requirements of titles XVIII and XIX of the Social Security Act [this subchapter and subchapter XIX of this chapter], community nursing and ambulatory care (as defined in subsection (b)(1)) which is generally available to individuals residing in the geographic area served by the organization, except that the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered.

“(4) The organization must make community nursing and ambulatory care (and such other health care services as such individuals have contracted for) available and accessible to each individual enrolled with the organization under this section, within the area served by the organization, with reasonable promptness and in a manner which assures continuity.

“(5) Section 1876(c)(5) of the Social Security Act [subsec. (c)(5) of this section] shall apply to organizations under this section in the same manner as it applies to organizations under section 1876 of such Act.

“(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals under the demonstration project. The organization must conduct under this section, which program (A) stresses health outcome and (B) provides review by health care professionals of the process followed in the provision of such health care services.

“(7) Under a demonstration project under this section—

“(A) The Secretary could require the organization to provide financial or other assurances (including financial risk-sharing) that minimize the inappropriate substitution of other services under title XVIII of such Act (this subchapter) for community nursing services; and

“(B) if the Secretary determines that the organization has failed to perform in accordance with the requirements of the project (including financial responsibility requirements under the project, any pattern of disproportionate or inappropriate institutionalization) the Secretary shall, after notice, terminate the project.

“(d) Determination of Per Capita Payment Rates.—
“(1) The Secretary shall determine for each 12-month period in which a demonstration project is conducted under this section, and shall announce (in a manner intended to provide notice to interested parties) not later than three months before the beginning of such period, with respect to each eligible organization conducting a demonstration project under this section, a per capita rate of payment for each class of individuals who are enrolled with such organization who are entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act (Part A and part B of this subchapter).

“(2)(A) Except as provided in paragraph (3), the per capita rate of payment under paragraph (1) shall be determined by the Secretary in accordance with this paragraph.

“(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

“(C) For purposes of subparagraph (B), the term ‘adjusted average per capita cost’ means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or prospective actuarial equivalence) would be payable in any contract year for those services covered under parts A and B of title XVIII of the Social Security Act [parts A and B of this subchapter] and types of expenses otherwise reimbursable under such parts A and B which are described in subparagraphs (A) through (D) of subsection (b)(1) (including administrative costs incurred by organizations described in sections 1816 and 1842 of such Act [sections 1395sh and 1395u of this title]), if the services were to be furnished by other than an eligible organization.

“(3) The Secretary shall, in consultation with providers, health policy experts, and consumer groups, develop capitation-based reimbursement rates for such classes of individuals entitled to benefits under part A and enrolled under part B of the Social Security Act [probably means parts A and B of title XVIII of that Act] for the plan under this section with the organization, and entitled to benefits under part A and enrolled under part B of the Social Security Act [probably means parts A and B of title XVIII of that Act] for the subchapter, if they were not members of an eligible organization.

“(4)(A) In the case of an eligible organization conducting a demonstration project under this section, the Secretary shall make monthly payments in advance and according to the amount determined under paragraph (2) or (3), except as provided in subsection (e)(3)(B), to the organization for each individual enrolled with the organization.

“(B) The amount of payment under paragraph (2) or (3) may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

“(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under such Act [this chapter] in such proportions to each such trust fund as the Secretary finds to be fair and equitable taking into consideration benefits attributable to such parts A and B, respectively.

“(6) During any period in which an individual is enrolled with an eligible organization conducting a demonstration project under this section, only the eligible organization (and no other individual or person) shall be entitled to receive payments from the Secretary under this title [probably means title XVIII of the Social Security Act, this subchapter] for community nursing and ambulatory care covered under parts A and B of title XVIII of the Social Security Act [as defined in section 1876(e)(3) of the Social Security Act].
“(C) An organization conducting a demonstration project under this section may provide (with the approval of the Secretary) that a part of the value of such additional benefits under subparagraph (A) be withheld and reserved by the Secretary as provided in section 1876(g)(5) of the Social Security Act [subsec. (g)(5) of this section].”

“(4) The provisions of paragraphs (3), (5), and (6) of section 1876(g) of the Social Security Act [subsec. (g)(3), (5), and (6) of this section] shall apply in the same manner to agreements under this section as they apply to risk-sharing contracts under section 1876 of such Act, and, for this purpose, any reference in such paragraphs to paragraph (2) is deemed a reference to paragraph (3) of this subsection.”

“STUDY OF AAPCC AND ACR

Section 6312(g) of Pub. L. 99–509 directed Secretary of Health and Human Services to provide, through contracts with appropriate organizations, for a study of the methods by which the adjusted community rate (“ACR”, as defined in subsec. (a)(4) of this section) may be applied, at the organization’s option, to offset the amount of any reduction in payment amounts to the organization effected under Pub. L. 100–203, title IV, § 4013, Dec. 22, 1987, 101 Stat. 1330–61; Pub. L. 100–360, title IV, § 411(c)(3), July 1, 1988, 102 Stat. 773, prohibited Secretary of Health and Human Services from approving the establishment of a stabilization fund by an eligible organization under subsec. (g)(5) of this section for any contract period beginning later than Sept. 30, 1990, and directed Secretary to report to Congress with respect to use of stabilization funds by eligible organizations under subsec. (g)(5) of this section and to assess the need for such funds not later than 54 months after July 1984, prior to repeal by Pub. L. 101–239, title VI, § 6212(c)(1), Dec. 19, 1989, 103 Stat. 2250.”

STUDY OF ADDITIONAL BENEFITS SELECTED BY ELIGIBLE ORGANIZATIONS

Section 114(d) of Pub. L. 97–248 directed Secretary of Health and Human Services to conduct a study of the additional benefits selected by eligible organizations pursuant to subsec. (g)(2) of this section, with Secretary to report to Congress within 18 months of initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248) with respect to the findings and conclusions made as a result of such study.

STUDY EVALUATING THE EXTENT OF, AND REASONS FOR, TERMINATION BY MEDICARE BENEFICIARIES OF MEMBERSHIP IN ORGANIZATIONS WITH CONTRACTS UNDER THIS SECTION

Section 114(e) of Pub. L. 97–248 directed Secretary of Health and Human Services to conduct a study evaluating the extent of, and reasons for, the termination by Medicare beneficiaries of their enrollments in organizations with contracts under section 1876 of the Social Security Act (this section), with Secretary to submit an interim report to Congress, within two years after the initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248), and a final report within five years after such date containing the respective interim and final findings and conclusions made as a result of such study..

REIMBURSEMENT FOR SERVICES

Section 226(b) of Pub. L. 92–603 provided that:

“(1) Notwithstanding the provisions of section 1814 and section 1853 of the Social Security Act [sections 1395f and 1395i of this title], any health maintenance organization which has entered into a contract with the Secretary pursuant to section 1876 of such Act [this section] for individuals who are members of such organization to be provided by that organization, between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act [this section] for services rendered to them, chose (in accordance with regulations) not to have such payment made pursuant to such section, the Secretary shall, for a period not to exceed three years commencing on July 1, 1973, pay to such organization on the basis of an interim per capita rate, determined in accordance with the provisions of section 1876(a)(2) of such Act [subsection (a)(2) of this section], with appropriate actuarial adjustments to reflect the difference in utilization of out-of-plan services, which would have been considered sufficiently reasonable and necessary under the rules of the health maintenance organization to be provided by that organization, between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act [this section]. Payments under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

“(2) With respect to individuals who are members of organizations which have entered into a risk-sharing contract with the Secretary pursuant to subsection (1)(a)(2)(A) of this section prior to July 1, 1973, and who, although eligible to have payment made pursuant to section 1876 of such Act [this section] for services rendered to them, chose (in accordance with regulations) not to have such payment made pursuant to such section, the Secretary shall, for a period not to exceed three years commencing on July 1, 1973, pay to such organization on the basis of an interim per capita rate, determined in accordance with the provisions of section 1876(a)(2) of such Act [subsection (a)(2) of this section], with appropriate actuarial adjustments to reflect the difference in utilization of out-of-plan services, which would have been considered sufficiently reasonable and necessary under the rules of the health maintenance organization to be provided by that organization, between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act [this section]. Payments under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

“(3) If the Secretary determines that the present cost of any such organization in any contract year for providing services to individuals described in paragraph
(2), when combined with the cost of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such year for providing out-of-plan services to such individuals, is less than or greater than the adjusted average per capita cost (as defined in section 1876(a)(3) of such Act) [subsec. (a)(3) of this section] of providing such services, the resulting savings shall be apportioned between such organization and such Trust Funds, or the resulting losses shall be absorbed by such organization, in the manner prescribed in section 1876(a)(3) of such Act [subsec. (a)(3) of this section]."

Section Referred To in Other Sections
This section is referred to in sections 1320a–1, 1320a–7, 1320a–7b, 1320c–2, 1320c–3, 1395f, 1395l, 1395w–4, 1395w–21, 1395w–23, 1395w–26, 1395x, 1395cc, 1395nn, 1395ss, 1395ww, 1395ccc, 1395eee, 1396a, 1396b, 1396d, 1396u–2, 1396u–4 of this title; title 2 section 906.

§ 1395nn. Limitation on certain physician referrals

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter, and

except as provided in subsection (e) of this section, an ownership or investment interest in the entity, or

(B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the organization, or an immediate family member of such physician) with the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions

Subsection (a)(1) of this section shall not apply in the following cases:

(1) Physicians’ services

In the case of physicians’ services (as defined in section 1395x(a) of this title) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4) of this section) as the referring physician.

(2) In-office ancillary services

In the case of services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)—

(A) that are furnished—

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

(ii) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians’ services unrelated to the furnishing of designated health services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice—

(aa) for the provision of some or all of the group’s clinical laboratory services, or

(bb) for the centralized provision of the group’s designated health services (other than clinical laboratory services), unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) Prepaid plans

In the case of services furnished by an organization—

(A) with a contract under section 1395mm of this title to an individual enrolled with the organization,

(B) described in section 1395(1)(A) of this title to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under section 1395b–1(a) of this title or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization,

(D) that is a qualified health maintenance organization (within the meaning of section 330e–9(d) of this title) to an individual enrolled with the organization, or

(E) that is a Medicare+Choice organization (as defined in part C of this subchapter that is offering a coordinated care plan described in sec-

1 See References in Text note below.
iv. the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(b) Equipment

Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee’s pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(4) Other permissible exceptions

In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(c) General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds

Ownership of the following shall not not be considered to be an ownership or investment interest described in subsection (a)(2)(A) of this section:

(1) Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which may be purchased on terms generally available to the public and which are—

(A)(i) securities listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or

(B) in a corporation that had, at the end of the corporation’s most recent fiscal year, or on average during the previous 3 fiscal years, stockholder equity exceeding $75,000,000.

(2) Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if such company had, at the end of the company’s most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75,000,000.

(d) Additional exceptions related only to ownership or investment prohibition

The following, if not otherwise excepted under subsection (b) of this section, shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A) of this section:

(1) Hospitals in Puerto Rico

In the case of designated health services provided by a hospital located in Puerto Rico.

(2) Rural provider

In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area.

(3) Hospital ownership

In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services at the hospital, and

(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

(e) Exceptions relating to other compensation arrangements

The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B) of this section:

(1) Rental of office space; rental of equipment

(A) Office space

Payments made by a lessee to a lessor for the use of premises if—

(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee’s pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Equipment

Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee,

(iii) the lease provides for a term of rental or lease of at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.
(2) Bona fide employment relationships

Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—
(A) the employment is for identifiable services,
(B) the amount of the remuneration under the employment—
(i) is consistent with the fair market value of the services, and
(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,
(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and
(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

(3) Personal service arrangements

(A) In general

Remuneration from an entity under an arrangement (including remuneration for specific physicians’ services furnished to a non-profit blood center) if—
(i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,
(ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,
(iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,
(iv) the term of the arrangement is for at least 1 year,
(v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,
(vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and
(vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Physician incentive plan exception

(i) In general

In the case of a physician incentive plan (as defined in clause (ii) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1395mm(i)(8)(A)(ii) of this title, the plan complies with any requirements the Secretary may impose pursuant to such section.

(III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

(ii) “Physician incentive plan” defined

For purposes of this subparagraph, the term “physician incentive plan” means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(4) Remuneration unrelated to the provision of designated health services

In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

(5) Physician recruitment

In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

(A) the physician is not required to refer patients to the hospital,
(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and
(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.
(6) Isolated transactions
In the case of an isolated financial transaction, such as a one-time sale of property or practice, if—

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(7) Certain group practice arrangements with a hospital
(A) In general
An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if—

(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1395x(b)(3) of this title,

(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the services to be provided by the parties and the compensation for services provided under the agreement,

(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Payments by a physician for items and services
Payments made by a physician—

(A) to a laboratory in exchange for the provision of clinical laboratory services, or

(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

(f) Reporting requirements
Each entity providing covered items or services for which payment may be made under this subchapter shall provide the Secretary with the information concerning the entity’s ownership, investment, and compensation arrangements, including—

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A) of this section), or with a compensation arrangement (as described in subsection (a)(2)(B) of this section), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this subchapter very infrequently.

(g) Sanctions

(1) Denial of payment
No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1) of this section.

(2) Requiring refunds for certain claims
If a person collects any amounts that were billed in violation of subsection (a)(1) of this section, the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims
Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under this subchapter shall be subject to a civil money penalty of not more than $100,000 for each such arrangement.

(4) Civil money penalty and exclusion for circumvention schemes
Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrange-
ment or scheme. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(5) Failure to report information

Any person who is required, but fails, to meet a reporting requirement of subsection (f) of this section is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Advisory opinions

(A) In general

The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Application of certain rules

The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) of this section and take into account the regulations promulgated under subsection (b)(5) of section 1320a–7d of this title in the issuance of advisory opinions under this paragraph.

(C) Regulations

In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(D) Applicability

This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after August 5, 1997, and before the close of the period described in section 1320a–7d(b)(6) of this title.

(b) Definitions and special rules

For purposes of this section:

(1) Compensation arrangement; remuneration

(A) The term “compensation arrangement” means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than an arrangement involving only remuneration described in subparagraph (C).

(B) The term “remuneration” includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(ii) The provision of items, devices, or supplies that are used solely to—

(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

(II) order or communicate the results of tests or procedures for such entity.

(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

(I) the health services are not furnished, and

(ii) the payment is made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) Employee

An individual is considered to be “employed by” or an “employee” of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

(3) Fair market value

The term “fair market value” means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) Group practice

(A) Definition of group practice

The term “group practice” means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(i) in which each physician who is a member of the group provides substantially the full range of services which the
physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel.

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group.

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician.

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) Special rules

(i) Profits and productivity bonuses

A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

(ii) Faculty practice plans

In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(5) Referral; referring physician

(A) Physicians’ services

Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B of this subchapter, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a “referral” by a “referring physician”.

(B) Other items

Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the designated health service constitutes a “referral” by a “referring physician”.

(C) Clarification respecting certain services integral to a consultation by certain specialists

A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a “referral” by a “referring physician”.

(6) Designated health services

The term “designated health services” means any of the following items or services:

(A) Clinical laboratory services.

(B) Physical therapy services.

(C) Occupational therapy services.

(D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services.

(E) Radiation therapy services and supplies.

(F) Durable medical equipment and supplies.

(G) Parenteral and enteral nutrients, equipment, and supplies.

(H) Prosthetics, orthotics, and prosthetic devices and supplies.

(I) Home health services.

(J) Outpatient prescription drugs.

(K) Inpatient and outpatient hospital services.

REFERENCES IN TEXT

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b)(3)(C), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

Section 300e–9(d) of this title, referred to in subsec. (b)(3)(D), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

Part C of this subchapter, referred to in subsec. (b)(3)(E), is classified to section 1395w–21 et seq. of this title.

The Internal Revenue Code, referred to in subsecs. (c)(2) and (h)(2), is classified generally to Title 26, Internal Revenue Code.

Part B of this subchapter, referred to in subsec. (h)(5)(A), is classified to section 1395 et seq. of this title.

PRIOR PROVISIONS


AMENDMENTS


Section 152(d)(1) of Pub. L. 103–432 provided that:

"The amendment made by this section [amending this section] shall apply to referrals made on or after January 1, 1995.''

"The amendments made by subsections (a) and (b) [amending this section] shall apply to referrals made on or after January 1, 1995."
42 USC § 1395oo PROVIDER REIMBURSEMENT REVIEW BOARD 

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the “Board”) which shall be established by the Secretary in accordance with subsection (b) of this section (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supple-

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**Section 1395oo. Provider Reimbursement Review Board**

**Effective Date of 1993 Amendment**


“(1) GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS


**Statistical Summary of Comparative Utilization**


**GAO Study of Ownership by Referring Physicians**


**Section Referred to in Other Sections**

This section is referred to in section 1396b of this title.

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**Effective Date of 1990 Amendment**


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**Deadline for Certain Regulations**


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**Effective Date of 1993 Amendment**


“(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to referrals—

(A) made on or after January 1, 1992, in the case of clinical laboratory services, and

(B) made after December 31, 1994, in the case of other designated health services.

(2) EXCEPTIONS.—With respect to referrals made for clinical laboratory services on or before December 31, 1994—

(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2) of section 1877 of the Social Security Act [subsecs. (a)(2), (b)(2)(B), and (d)(2) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

(B) section 1877(b)(4) of the Social Security Act [subsec. (b)(4) of this section] (as in effect on the day before the date of the enactment of this Act) shall apply;

(C) the requirements of section 1877(c)(2) of the Social Security Act [subsec. (c)(2) of this section] (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

(D) section 1877(e)(3) of the Social Security Act [subsec. (e)(3) of this section] (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

(E) the requirements of clauses (iv) and (v) of section 1877(b)(4)(B), of the Social Security Act [subsec. (h)(4)(A)(iv), (v), (B)(i) of this section] (as amended by this Act) shall not apply; and

(F) section 1877(b)(4)(B) of the Social Security Act [subsec. (h)(4)(B) of this section] (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).”

Section 1395oo. Provider Reimbursement Review Board

This section is referred to in section 1396b of this title.
The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing even though inadmissible, under rules of evidence applicable to court procedure.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to the Secretary with respect to subchapter II of this chapter.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subparts shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmation, or modification by the Secretary if the Board or of any reversal, affirmation, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notice of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.
(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) “Provider of services” defined

In this section, the term “provider of services” includes a rural health clinic and a Federally qualified health center.


REFERENCES IN TEXT

The provisions of title 5 governing appointments in the competitive service, referred to in subsec. (h), are classified to section 3301 et seq. of Title 5, Government Organization and Employees.

AMENDMENTS


Subsec. (e). Pub. L. 98–369, § 2354(b)(40), substituted “and (e)” for “, (e), and (f)”.

Subsec. (f)(1). Pub. L. 98–369, § 2351(a)(1), substituted “notification of such determination is received” for “such determination is rendered” in third sentence.

1983—Subsec. (a), Pub. L. 98–21, § 602(b)(1)(A), inserted provision in introductory text that, except as provided in subsec. (g)(2) of this section, any hospital which receives payments in amounts computed under section 1395ww(b) or (d) of this title and which has submitted such reports within such time as Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by Board.


Subsec. (a)(3). Pub. L. 98–21, § 602(b)(1)(D), substituted “(1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii)” for “(1)(A)(i), or (e) or (f)”.

Subsec. (f)(1). Pub. L. 98–21, § 602(b)(2), inserted “(or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located)” after “the judicial district in which the provider is located”, and “Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers.”

Subsec. (g). Pub. L. 98–21, § 602(b)(3), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 98–21, § 602(h)(4), substituted “payment of providers of services” for “cost reimbursement”.

1980—Subsec. (f)(1). Pub. L. 96–499 inserted provision empowering providers of services to obtain judicial review of any action of a fiscal intermediary involving a question of law or regulations relevant to matters in controversy whenever Board determined that it was without authority to decide such matters in controversy.

1974—Subsec. (f). Pub. L. 93–484 redesignated existing provisions as par. (1), inserted provisions authorizing judicial review for providers of final decisions of Board and judicial review for any affirmance by Secretary, and added pars. (2) and (3).

EFFECTIVE DATE OF 1993 AMENDMENT


EFFECTIVE DATE OF 1990 AMENDMENT


Amendment by section 4161(b)(4) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(b)(d) of Pub. L. 101–508, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Section 2351(a)(2) of Pub. L. 98–369 provided that: “The amendment made by paragraph (1) [amending this section] shall be effective with respect to any civil action commenced on or after the date of the enactment of this Act [July 18, 1984].”

Section 2351(b)(2) of Pub. L. 98–369 provided that: “The amendment made by paragraph (1) [amending this
section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(38), (40) 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.

**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. See, also, section 2351(c) of Pub. L. 98–369, set out as a note below.

**Effective Date of 1974 Amendment**

Section 3(b) of Pub. L. 93–484 provided that: "The amendment made by subsection (a) [amending this section] shall be applied to cost reports of providers of services for accounting periods ending on or after June 30, 1973."

**References in Other Laws to GS–16, 17, or 18 Pay Rates**

References in laws to the rates of pay for GS–16, 17, or 18, or to maximum rates of pay under the General Schedule, to be considered references to rates payable under specified sections of Title 5, Government Organization and Employees, see section 529 [title I, §101(c)(1)] of Pub. L. 101–509, set out in a note under section 5376 of Title 5.

**Review of Provider Reimbursement Review Board Decisions**

Section 2351(c) of Pub. L. 98–369 provided that: "Notwithstanding section 604 of the Social Security Amendments of 1983 (Public Law 98–21) [set out as an Effective Date of 1983 Amendments note under section 1395ww of this title]--

"(1) the amendments made by section 602(h)(2)(A) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after April 20, 1983; and

"(2) the amendments made by section 602(h)(2)(B) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984]."

**Section Referred to in Other Sections**

This section is referred to in sections 256c, 1395h, 1395i–5, 1395j, 1395rr, 1395ww, 1395yy, 1395fff of this title.

**§ 1395pp. Limitation on liability where claims are disallowed**

(a) Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g) of this section, payment may not be made under part A or part B of this subchapter for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(i) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B of this subchapter,

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) and section 1395y(a)(9) of this title did not apply and as though the coverage denial described in subsection (g) of this section had not occurred. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g) of this section shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such individual or other person has been notified by the Secretary (including notification by a utilization and quality control peer review organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

(b) Knowledge of person or provider that payment could not be made; indemnification of individual

In any case in which the provisions of paragraphs (1) and (2) of subsection (a) of this section are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B of this subchapter, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs) for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to
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such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services. No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made on behalf of the individual under this subchapter.

(c) Knowledge of both provider and individual to whom items or services were furnished that payment could not be made

No payments shall be made under this subchapter in any cases in which the provisions of paragraph (1) of subsection (a) of this section are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B of this subchapter by reason of section 1395y(a)(1) or (a)(9) of this title or by reason of a coverage denial described in subsection (g) of this section.

(d) Exercise of rights

In any case arising under subsection (b) of this section (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c) of this section, the provider or other person shall have the same rights that an individual has under sections 1395ff(b) and 1395u(b)(3)(C) of this title (as may be applicable) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Payment where beneficiary not at fault

Where payment for inpatient hospital services or extended care services may not be made under part A of this subchapter on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1395f(a)(2)(C) of this title in that the individual—

(A) is or was not confined to his home, or

(B) does or did not need skilled nursing care on an intermittent basis; and

(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) of this section.

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2) of this section, including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this subchapter with respect to the services.

(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The agency complies with requirements of the Secretary under this subchapter respecting timely submittal of bills for payment and medical documentation.

(B) The agency program has reasonable procedures to notify promptly each patient (and the patient’s physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this subchapter.

(4)(A) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) of this section does not exceed 2.5 percent, computed based on visits for home health services billed.

(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.

(5) In this subsection, the term “fiscal intermediary” means, with respect to a home health agency, an agency or organization with an agreement under section 1395h of this title with respect to the agency.

(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

(g) Coverage denial defined

The coverage denial described in this subsection is—

(1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1395f(a)(2)(C) of this title or section 1395m(a)(2)(A) of this title in that the individual—

(A) is or was not confined to his home, or

(B) does or did not need skilled nursing care on an intermittent basis; and
(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

(h) Supplier responsibility for items furnished on assignment basis

If a supplier of medical equipment and supplies (as defined in section 1395m(j)(5) of this title)—

(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(j)(1) of this title;

(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1395m(a)(15) of this title; or

(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(a)(17)(B) of this title, any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1395m(a)(18) of this title shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.


REFERENCES IN TEXT

Parts A and B of this subchapter, referred to in text, are classified to sections 1395c et seq. and 1395d et seq., respectively, of this title.

AMENDMENTS

1997—Subsec. (g). Pub. L. 105–33 substituted “subsection (g)” for “subsection is”; redesignated remaining text as par. (1) and former paras. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, substituted “and” for period at end, and added par. (2).


1989—Subsec. (f)(1). Pub. L. 101–239, §6214(a)(1), struck out “with respect to any coverage denial described in subsection (g) of this section” before period at end.


1987—Subsec. (b). Pub. L. 100–203 struck out “subject to the deductible and coinsurance provisions of this subchapter,” after “(referred to in such paragraphs)” and inserted at end “No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this subchapter.”

1986—Subsec. (a). Pub. L. 99–509, §9305(g)(1)(A)–(C), inserted in par. (1) “or by reason of a coverage denial described in subsection (g) of this section”, and in concluding provisions inserted “and as though the coverage denial described in subsection (g) of this section had not occurred” and “or by reason of a coverage denial described in subsection (g) of this section”.

Subsec. (c). Pub. L. 99–509, §9305(g)(1)(D), inserted “or by reason of a coverage denial described in subsection (g) of this section”.

Subsec. (d). Pub. L. 99–509, §9341(a)(3), substituted “sections 1395f(b) and 1395u(b)(3)(C) of this title (as may be applicable)” for “section 1395f(b) of this title (when the determination is under part A) or section 1395u(b)(3)(C) of this title (when the determination is under part B)”.

Subsecs. (f), (g). Pub. L. 99–509, §9305(g)(1)(E), added subsecs. (f) and (g).

1982—Subsec. (a). Pub. L. 97–248, §145, inserted provisions relating to imputing knowledge to provider or other person furnishing items or services for which payment may not be made that payment may not be made if the provider or other person has been notified that a pattern of inappropriate utilization has occurred in the past and there has been a reasonable time for correction of such utilization.

Subsec. (c). Pub. L. 97–248, §145(e), substituted “quality control and peer review organization” for “professional standards review organization.


EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to benefits provided on or after Aug. 3, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to items or services furnished on or after Jan. 1, 1995, see section 105 of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Section 6214(c) of Pub. L. 101–239 provided that: “The amendments made by subsection (a) (amending this section) shall apply to determinations for quarters beginning on or after the date of the enactment of this Act (Dec. 19, 1989).”

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Section 9305(g)(3) of Pub. L. 99–509, as amended by Pub. L. 100–360, title IV, §§426(c), 4444, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to coverage denials occurring on or after July 1, 1987, and before December 31, 1986.”

Amendment by section 9341(a)(3) of Pub. L. 99–509 applicable to items and services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1980 AMENDMENT

Section 956(b) of Pub. L. 96–499 provided that: “The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1981.”
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Effective Date

Section 213(b) of Pub. L. 92–683 provided that: "The amendments made by this section (enacting this section) shall be effective with respect to claims under part A or part B of title XVIII of the Social Security Act [part A or part B of this subchapter], filed with respect to items or services furnished after the date of the enactment of this Act [Oct. 30, 1972]."

Reports to Congress on Denials of Bills for Payment

Section 1909(g)(2) of Pub. L. 99–509 directed Secretary of Health and Human Services to report to Congress annually in March of 1987 and 1988 information on frequency and distribution (by type of provider) of denials of bills for payment under this subchapter for extended care services, home health services, and hospice care, by reason of section 1395(q) or (q) of this title, and coverage denials described in subsec. (g) of this section, and such other information as appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

Section Referred to in Other Sections

This section is referred to in sections 1395c–3, 1395h–1, 1395f of this title.

§ 1395qq. Indian health service facilities

(a) Eligibility for payments; conditions and requirements

A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for payments under this subchapter, notwithstanding sections 1395(f) and 1395(m)(d) of this title, if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this subchapter.

(b) Eligibility based on submission of plan to achieve compliance with conditions and requirements; twelve-month period

Notwithstanding subsection (a) of this section, a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this subchapter which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Payments into special fund for improvements to achieve compliance with conditions and requirements; certification of compliance by Secretary

Notwithstanding any other provision of this subchapter, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this subchapter. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) Report by Secretary; status of facilities in complying with conditions and requirements

The annual report of the Secretary which is required by section 1671 of title 25 shall include (along with the matters specified in section 1643 of title 25) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this subchapter and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) of this section and otherwise) toward the achievement of such compliance.


Amendments


Demonstration Program for Direct Billing of Medicare, Medicaid, and Other Third Party Payers

Pub. L. 94–437, title IV, § 405, as added by Pub. L. 102–713, title IV, § 402, Nov. 23, 1988, 102 Stat. 4818, formerly set out as a note under this section, was transferred and is set out as section 1645 of Title 25, Indians.

Medicare Payments Not Considered in Determining Appropriations for Indian Health Care

Section 401(c) of Pub. L. 94–437 provided that any payments received for services provided to beneficiaries under this section were not to be considered in determining appropriations for health care and services to Indians, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1999, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

Preference in Services for Indians With Medicare Coverage Not Authorized

Section 401(d) of Pub. L. 94–437, which provided that nothing in this section authorized the Secretary to provide services to an Indian beneficiary with coverage under this subchapter, in preference to an Indian beneficiary without such coverage, was omitted in the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1999, 106 Stat. 4565. Similar provisions are contained in section 401(b) of Pub. L. 94–437, which is classified to section 1641(b) of Title 25, Indians.

Section Referred to in Other Sections

This section is referred to in sections 1395f, 1395n of this title; title 25 section 1880c.
§ 1395rr. End stage renal disease program

(a) Type, duration, and scope of benefits

The benefits provided by parts A and B of this subchapter shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 426–1 of this title, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this subchapter, the type, duration, and scope of the benefits provided by parts A and B of this subchapter shall include requirements for a minimum utilization rate for transplantations.

(b) Payments with respect to services; dialysis; regulations; physicians’ services; target reimbursement rates; home dialysis supplies and equipment; self-care home dialysis support services; self-care dialysis units; hepatitis B vaccine

(1) Payments under this subchapter with respect to services, in addition to services for which payment would otherwise be made under this subchapter, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A) of this subsection, (B) payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1395x(s)(2)(P) of this title if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section). The requirements prescribed by the Secretary under subparagraph (B) shall include requirements for a minimum utilization rate for transplantations.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease, the Secretary shall—

(1) make payments on behalf of all such individuals that are comparable to prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis determined in accordance with section 1395w–4 of this title (if applicable), except such payments (which amounts shall not exceed, in respect to costs in procurements attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1395x(v) of this title or section 1395ww of this title (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1395(b) of this title.

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

(C) Such regulations, in the case of services furnished by proprietary providers (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1395x(v)(1)(B) of this title.

(D) For purposes of section 1395oo of this title, a renal dialysis facility shall be treated as a provider of services.

(3) With respect to payments for physicians’ services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

(B) on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations).

(4)(A) Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients...
whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)) or on the basis of a method established under paragraph (7).

(b) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

(A) assume full responsibility for directly obtaining or arranging for the provision of—

(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

(ii) dialysis equipment maintenance and repair services;

(iii) the purchase and delivery of all necessary medical supplies; and

(iv) where necessary, the services of trained home dialysis aides;

(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility’s home dialysis patient population; and

(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

(A) the Secretary’s estimate of the cost of providing medically necessary home dialysis supplies and equipment;

(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event (except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target payment rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure (including methods established under paragraph (7)) which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities, and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required...
to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A) of this section) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2) of this section. The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) of this section to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) the geographic size of the network area;
(B) the number of providers of end stage renal disease services in the network area;
(C) the number of individuals who are entitled to end stage renal disease services in the network area; and
(D) the proportion of the aggregate administrative funds collected in the network area.

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000.

(8) For purposes of this subchapter, the term "home dialysis supplies and equipment" means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

(9) For purposes of this subchapter, the term "self-care home dialysis support services", to the extent permitted in regulation, means—

(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;
(B) installation and maintenance of dialysis equipment;
(C) testing and appropriate treatment of the water; and
(D) such additional supportive services as the Secretary finds appropriate and desirable.

(10) For purposes of this subchapter, the term "self-care dialysis unit" means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

(11)(A) Hepatitis B vaccine and its administration, when provided to a patient determined to have end stage renal disease, shall not be included as dialysis services for purposes of payment under any prospective payment amount or comprehensive fee established under this section. Payment for such vaccine and its administration shall be made separately in accordance with section 1395f of this title.

(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and payment for such item shall be made separately—

(i) in the case of erythropoietin provided by a physician, in accordance with section 1395f of this title; and
(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

(I) for erythropoietin provided during 1994, in an amount equal to $10 per thousand units (rounded to the nearest 100 units), and

(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.

(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.

(c) Renal disease network areas; coordinating councils, executive committees, and medical review boards; national end stage renal disease medical information system; functions of network organizations

(1)(A)(I) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a
membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(i)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2).

The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

(ii) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1395x(s)(2)(F) of this title, or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and to assure the maintenance of the registry established under paragraph (7);

(G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

(H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network, in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals or to follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement.
with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network’s goals and performance as reflected in the network’s annual report.

(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks’ goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation.

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

(A) the preparation of the annual report to the Congress required under subsection (g) of this section;

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

(8) The provisions of sections 1320c-6 and 1320c-9 of this title shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.

(d) Donors of kidney for transplant surgery

Notwithstanding any provision to the contrary in section 426 of this title any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this subchapter with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this subchapter), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this subchapter without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

(e) Reimbursement of providers, facilities, and nonprofit entities for costs of artificial kidney and automated dialysis peritoneal machines for home dialysis

(1) Notwithstanding any other provision of this subchapter, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities, and nonprofit entities (without regard to the deductible and coinsurance provisions of this subchapter) for the reasonable cost of the purchase, installation, maintenance and reconditioning of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider, facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment;

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term “supportive equipment” includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

(f) Experiments, studies, and pilot projects

(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals
suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this subchapter, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this subchapter (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialysis filters for those facilities and providers which voluntarily elect to reuse such filters.

(B) With respect to dialysis services furnished on or after January 1, 1988 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines), no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) of this section and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g) Conditional approval of dialysis facilities; restriction-of-payments notice to public and facility; notice and hearing; judicial review

(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A) of this section,

(B) finds that the facility’s deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this subchapter shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary’s decision to restrict payments under this subsection shall be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A) of this section, or (B) the Secretary terminates the agreement under this subchapter with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(g) of this title thereto, any reference thereto to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.
REFERENCES IN TEXT

AMENDMENTS
1994—Subsec. (g)(3). Pub. L. 103–296 inserted before period at end "except that, in so applying such sections and in applying section 1039(i)(1) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".
1988—Subsec. (b)(1)(C). Pub. L. 100–203, §4065(b), substituted "section 1395x(s)(2)(P)" for "section 1395x(s)(2)(Q)".
1984—Subsec. (b)(11). Pub. L. 100–501, §4201(d)(2)(A), added subpars. (A) to (D). Former subpars. (D) to (F) redesignated (G) and (H), respectively.
1981—Subsec. (d)(7)(B). Pub. L. 100–203, §4036(d)(2)(B), redesignated subsec. (h) as (g) and struck out former subsec. (g) which directed the Secretary to submit to Congress on July 1, 1979, and on July 1 of each year thereafter a report on end stage renal disease programs.
1978—Subsec. (b)(7). Pub. L. 99–509, §9335(j)(1), inserted at end "The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) of this section for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2) of this section.
"Pub. L. 99–509, §9335(a)(2), inserted "and of pediatric facilities" after "isolated rural areas" in third sentence, and inserted after third sentence "Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed."
Subsec. (c)(1)(A). Pub. L. 99–509, §9335(d)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.
"Pub. L. 99–509, §9335(e), amended subpar. (B) generally, substituting "network council and each medical review board" for "coordinating council and executive committee."
Subsec. (c)(2)(A). Pub. L. 99–509, §9335(f)(1), inserted "and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs" before the semicolon.
Subsec. (c)(2)(B). Pub. L. 99–509, §9335(f)(2), inserted "and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs" before first semicolon.
Subsec. (c)(2)(D) to (F). Pub. L. 99–509, §9335(f)(5), added subpars. (D) to (F). Former subpars. (D) and (E) redesignated (G) and (H), respectively.
Subsec. (c)(2)(G). Pub. L. 99–509, §9335(f)(3), (5), redesignated former subpar. (D) as (G) and inserted "and reporting to the Secretary on facilities and providers that are not providing appropriate medical care" before the semicolon.
Subsec. (c)(2)(H). Pub. L. 99–509, §9335(f)(4), (5), redesignated former subpar. (E) as (H) and inserted "and encouraging participation in vocational rehabilitation programs" after "and transplantation."
Subsec. (c)(3). Pub. L. 99–509, §9335(g), inserted "or to follow the recommendations of the medical review board after "network plans and goals."

Subsec. (c)(6). Pub. L. 99–509, § 3835(h), inserted “and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment” at end of first sentence.


Subsec. (f)(7). Pub. L. 99–509, § 3835(k)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: “The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reuse of dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program.”

1984—Subsecs. (a), (b)(1), (2)(A), (B), (3), (8). Pub. L. 98–369, § 2354(b)(41), substituted “end stage” for “end-stage” wherever appearing.


Pub. L. 98–369, § 2323(c), added par. (11).

Subsec. (c)(6). Pub. L. 98–369, § 2332(a), inserted proviso that if the Secretary determines that the facility’s or provider’s failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.


1981—Subsec. (b)(2)(B). Pub. L. 97–35, § 2145(a)(3), substituted “(except as may be provided in regulations established under paragraph (7))” for “(except as may be provided in regulations promulgated under section (7))” and struck out provisions that such regulations provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services, and include a system for classifying comparable providers and facilities, and prospectively set rates or target rates with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services.

Subsec. (b)(3)(B). Pub. L. 97–35, § 2145(a)(3), substituted “or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis)” for “or other basis”.


Subsec. (b)(6). Pub. L. 97–35, § 2145(a)(5), (6), substituted “except as may be provided in regulations under paragraph (7)” for “shall such target rate exceed 75 percent” and “any other procedure (including methods established under paragraph (7)) which the Secretary” for “shall such target rate exceed 70 percent” and “any other procedure which the Secretary”, respectively.

Subsec. (b)(7) to (10). Pub. L. 97–35, § 2145(a)(7), (8), added par. (7) and redesignated former pars. (7) to (9) as (8) to (10), respectively.

1980—Subsec. (e)(1). Pub. L. 96–499, § 957(a)(1)–(3), substituted “services, renal dialysis facilities, and non-profit entities which the Secretary finds can furnish equipment economically and efficiently,” for “for services and renal dialysis facilities and ‘such providers, facilities, and non-profit entities’ for ‘‘such providers and facilities’.”

Subsec. (e)(2). Pub. L. 96–499, § 957(a)(4), substituted “facility, or other entity will” for “or facility will”.

Subsec. (g). Pub. L. 96–499, § 957(b), substituted “July” for “April” in two places.

Effective Date of 1994 Amendment

Effective Date of 1993 Amendment
Amendment by Pub. L. 103–66 applicable to erythropoietin furnished on or after Jan. 1, 1994, see section 13596(c) of Pub. L. 103–66, set out as a note under section 1385x of this title.

Effective Date of 1990 Amendment
Section 4201(c)(2) of Pub. L. 101–508 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to erythropoietin furnished on or after January 1, 1991.”

Amendment by section 4201(d)(2) of Pub. L. 101–508 applicable to items and services furnished on or after July 1, 1991, see section 4201(d)(3)(4) of Pub. L. 101–508, set out as a note under section 1385x of this title.

Effective Date of 1989 Amendment
Section 6203(b)(3) of Pub. L. 101–239 provided that: “The amendments made by this subsection [amending this section] shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990.”

Effective Date of 1987 Amendments
Amendment by section 4065(b) of Pub. L. 100–203 effective Jan. 1, 1988, see section 4065(c) of Pub. L. 100–203, set out as a note under section 1385x of this title.

Amendment by Pub. L. 100–53 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

Effective Date of 1986 Amendment
Section 9335(a)(3) of Pub. L. 99–509 provided that: “The amendments made by paragraph (2) [amending this section] shall apply to applications filed on or after the date of the enactment of this Act [Oct. 21, 1986].”

Section 9335(j)(2) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, § 4085(i)(1)(C), Dec. 22, 1987, 101 Stat. 1330–133, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to treatment furnished on or after January 1, 1987, except that, until network administrative organizations are established under section 1881(c)(1)(A) of the Social Security Act [subsec. (c)(1)(A) of this section] as amended by subsection (d)(1) of this section, the distribution of payments described in the last sentence of section 1881(b)(7) of such Act shall be made based on the distribution of payments under section 1881(b) of such Act to network administrative organizations for fiscal year 1986.”


Section 9335(j) of Pub. L. 99–509 provided that: “The amendments made by subsections (e), (f), and (g) [amending this section] shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1) [amending this section].”

Effective Date of 1984 Amendments
Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1385f of this title.

Amendment by section 2323(c) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1385f of this title.
Section 235(b) of Pub. L. 98–369 provided that: "The amendment made by this section [amending this section] shall apply to determinations made by the Secretary on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 235(b)(4) 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.

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.

Effective Date of 1981 Amendment
Section 214(b) of Pub. L. 97–35 provided that: "The amendments made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1981, and the Secretary of Health and Human Services shall first promulgate regulations to carry out section 1881(b)(7) of the Social Security Act [subsec. (b)(7) of this section] not later than October 1, 1981."

Effective Date
Section 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. 95–252, set out as an Effective Date of 1978 Amendment note under section 426 of this title.

Study on Payment Level for Home Hemodialysis

"The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the differential in payment under the medicare program for hemodialysis services furnished in a facility and such services furnished in a home. Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit to Congress a report on such study and shall include recommendations regarding changes in medicare payment policy in response to the study."

Renal Dialysis-related Services
Pub. L. 105–33, title IV, §4558, Aug. 5, 1997, 111 Stat. 463, provided that:

"(a) Auditing of Cost Reports.—Beginning with cost reports for 1996, the Secretary shall audit cost reports of each renal dialysis provider at least once every 3 years.

"(b) Implementation of Quality Standards.—The Secretary of Health and Human Services shall develop, by not later than January 1, 1999, and implement, by not later than January 1, 2006, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act [this subchapter]."

PROFAC Study on ESRD Composite Rates
Section 4201(b) of Pub. L. 101–508 provided that:

"(1) In general.—

"(A) Study.—The Prospective Payment Assessment Commission (in this subsection referred to as the 'Commission') shall conduct a study to determine which costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1998 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

"(i) hemodialysis and other modalities of treatment,

"(ii) the appropriate services to be included in such payments,

"(iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, and size and mix of services,

"(iv) adjustments for labor and nonlabor costs,

"(v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,

"(vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and

"(vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

"(2) Report.—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce [Committee on Energy and Commerce now Committee on Commerce] of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

"(3) Annual Report.—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce [Committee on Energy and Commerce now Committee on Commerce] of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.

"[Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395rr of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.]"
Secretary of Health and Human Services shall establish and carry out a 3-year demonstration project to determine whether the services of a home dialysis staff assistant providing services to a patient during hemodialysis treatment at the patient’s home may be covered under the Medicare program in a cost-effective manner that ensures patient safety.

(1) Number of Participants.—The total number of eligible patients receiving services under the demonstration project established under paragraph (1) may not exceed 800.

(2) Payments to Participating Providers and Facilities.—

(A) In General.—For purposes of subparagraph (A), the term ‘services of a home hemodialysis staff assistant’ means—

(i) technical assistance with the operation of a hemodialysis machine in the patient’s home and with such patient’s care during in-home hemodialysis; and

(ii) administration of medications within the patient’s home to maintain the patency of the extra corporeal circuit.

(B) Determination of Payment Amount.—(i) The amount of payment made under subparagraph (A) shall be the product of—

(I) two-thirds of the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act [subsec. (b)(7) of this section] adjusted for differences in area wage levels.

(ii) The rate determined under this clause, with respect to a provider of services or a renal dialysis facility, shall be equal to the difference between—

(I) the rate determined under clause (ii) with respect to a provider of services or a renal dialysis facility; and

(II) the factor by which the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act [subsec. (b)(7) of this section] is adjusted for differences in area wage levels.

(2) Coverage of Individuals Currently Receiving Services.—Any individual who, on the date of the enactment of this Act [Nov. 5, 1990], is receiving staff assistance under the experimental authority provided under section 1881(f)(2) of the Social Security Act [subsec. (f)(2) of this section] shall be deemed to be an eligible individual for purposes of this subsection.

(3) Continuation of Coverage Upon Termination of Project.—Notwithstanding any provision of title XVIII of the Social Security Act, any individual receiving services under the demonstration project established under subsection (a) as of the date of the termination of the project shall continue to be eligible for home hemodialysis staff assistance after such date under such title on the same terms and conditions as applied under the demonstration project.
take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

**STUDIES OF END-STAGE RENAL DISEASE PROGRAM**

Section 9335(d)(1)–(4) of Pub. L. 100–203 provided that:

"(1) The Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall arrange for a study of the end-stage renal disease program within the medicare program.

"(2) Among other things, the study shall address—

"(A) access to treatment by both individuals eligible for medicare benefits and those not eligible for such benefits;

"(B) the quality of care provided to end-stage renal disease beneficiaries, as measured by clinical indicators, functional status of patients, and patient satisfaction;

"(C) the effect of reimbursement on quality of treatment;

"(D) major epidemiological and demographic changes in the end-stage renal disease population that may affect access to treatment, the quality of care, or the resource requirements of the program; and

"(E) the adequacy of existing data systems to monitor these matters on a continuing basis.

"(3) The Secretary shall submit to Congress, not later than 3 years after the date of the enactment of this Act [Dec. 22, 1987], a report on the study.

"(4) The Secretary shall request the National Academy of Sciences, acting through the Institute of Medicine, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application."
§ 1395ss. Certification of medicare supplemental health insurance policies

(a) Submission of policy by insurer

(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1) of this section) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c) of this section. Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c) of this section. Subject to subsections (k)(3), (m), and (n) of this section, such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements, and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary’s certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) of this section unless—

(A) the State’s regulatory program under subsection (b)(1) of this section provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulation or 1991 Federal Regulation (as the case may be)) by the date specified in subsection (p)(1)(C) of this section; or

(B) if the State’s program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) of this section (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy on and after the effective date specified in subsection (p)(1)(C) of this section, in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(b) Standards and requirements; periodic review by Secretary

(1) Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that—

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A) of this section), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c) of this section;

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1) of this section) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t) of this section, shall be deemed (subject to subsections (k)(3), (m), and (n) of this section, for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in sub-
section (c) of this section. Each report required under subparagraph (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards and requirements of this paragraph, actions taken by the State to bring such policies into compliance, information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a Medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c) of this section, with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State’s option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.

(c) Requisite findings

The Secretary shall certify under this section any Medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (a) of this section, the issuer of the policy)—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t) of this section);

(2) meets the requirements of subsection (r) of this section;

(3)(A) accepts a notice under section 1395u(h)(3)(B) of this title respecting the policy are to be sent; and

(D) agrees to pay any user fees established under section 1395u(h)(3)(B) of this title with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (o) through (t) of this section.

(d) Criminal penalties; civil penalties for certain violations

(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) of this section or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a) of this section, shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this subchapter, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter (including an individual electing a Medicare+Choice plan under section 1395w–21 of this title)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this subchapter or subchapter XIX of this chapter,

(II) in the case of an individual not electing a Medicare+Choice plan a Medicare supplemental policy with knowledge that the individual is entitled to benefits under another Medicare supplemental policy or in the case of an individual electing a Medicare+Choice plan,
a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare-Choice plan or under another medicare supplemental policy, or

(II) Whoever issues or sells a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(ii) Whoever violates clause (i) shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i)(II) with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subchapter, under subchapter XIX of this chapter, under subchapter III of clause (i) do not apply to a policy in relation to health benefits under Medicare or other insurance.

(III) Whoever issues or sells a health insurance policy, a policy described in clause (v), or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

(iv) Any reference in this section to the revised NAIC model regulation (referred to in subclause (m)(1)(A) of this section) is deemed a reference to such regulation as revised by section 191(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before August 21, 1996) for that type of policy, as revised as follows:

(I) In each statement, amend the second line to read as follows:

"THIS IS NOT MEDICARE SUPPLEMENT INSURANCE".

(II) In each statement, strike the third line and insert the following: "Some health care services paid for by Medicare may also trigger the payment of benefits under this policy."

(III) In each statement not described in subclause (V), strike the boldface matter that begins "This insurance" and all that follows up to the next paragraph that begins "This insurance also covers...

(IV) In each statement not described in subclause (V), insert before the boxed matter (that states "Before You Buy This Insurance") the following: "This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance."

(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins "Federal law" to read as follows: "Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare."

(viii) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State’s ability to regulate health insurance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supple-
mental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter “duplicates” health benefits under this subchapter or under a Medicare supplemental policy.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (ii), a written statement signed by the individual stating, to the best of the individual’s knowledge, what health insurance policies (including any Medicare+Choice plan) the individual has, from what source, and whether the individual is entitled to any medical assistance under subchapter XIX of this chapter, whether as a qualified medicare beneficiary or otherwise, and

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy.

(II) states in substance that individuals may be eligible for benefits under the State medicaid program under subchapter XIX of this chapter and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such subchapter and may be re-instituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under subchapter XIX of this chapter, the sale of a medicare supplemental policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has a medicare supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer’s knowledge, duplicate coverage (taking into account any such replacement).

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under subchapter XIX of this chapter, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such subchapter pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1396d(p)(1) of this title, the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1396d(p)(3)(A)(i) of this title.

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed.

(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q) of this section.

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(5) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1320a–7(a) of this title.

(c) Dissemination of information

(1) The Secretary shall provide to all individuals entitled to benefits under this subchapter (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this subchapter.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) of

(i) the actions and practices that are subject to sanctions under subsection (d) of this section, and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f) Study and evaluation of comparative effectiveness of various State approaches to regulating medicare supplemental policies; report to Congress no later than January 1, 1982; periodic evaluations

(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this subchapter (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b) of this section.

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this subchapter.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for regulatory or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this subchapter of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under subchapter XIX of this chapter to such policies).

(g) Definitions

(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section
1395s(a)(1)(A) of this title. For purposes of this section, the term “policy” includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term “NAIC Model Standards” means the “NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act”, adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplemental policies.

(B) The term “State” with an approved regulatory program” means a State for which the Secretary has made a determination under subsection (b)(1) of this section.

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) Rules and regulations

The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) of this section not later than March 1, 1982.

(i) Commencement of certification program

(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) of this section until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) of this section with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to regulate such State has a program that meets the standards and requirements of subsection (b)(1) of this section.

(B) The date specified in this subparagraph for such State to adopt and implement a State regulatory program meeting applicable standards

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n) of this section)—

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So in original. Probably should be “supplemental”. counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) State regulation of policies issued in other States

Nothing in this section shall be construed so as to affect the right of any State to regulate any medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k) Amended NAIC Model Regulation or Federal model standards applicable; effective date; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on July 1, 1988, the National Association of Insurance Commissioners (in this subsection referred to as the “Association”) amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, except as provided in subsection (m) of this section, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) of this section referred to as the “amended NAIC Model Regulation”).

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) of this section referred to as “Federal model standards”) for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n) of this section)—
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(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a) of this section,
(B) no certification made pursuant to subsection (a) of this section shall remain in effect, and
(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A) of this section,

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(i) Transitional compliance with NAIC Model Transition Regulation; “qualifying medicare supplemental policy” and “NAIC Model Transition Regulation” defined

(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—
   (A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B of such Regulation) by January 1, 1989; or
   (B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term “qualifying medicare supplemental policy” means a medicare supplemental policy—
   (A) issued in a State which—
     (i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and
     (ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and
   (B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of—
   (i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or
   (ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) of this section (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as—
   (i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but
   (ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—
   (A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but
   (B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) of this section unless each individual who is entitled to benefits under this subchapter and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form not later than January 31, 1989, that explains—
   (A) the improved benefits under this subchapter contained in the Medicare Catastrophic Coverage Act of 1988, and
   (B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term “NAIC Model Transition Regulation” refers to the standards contained in the “Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions” (as adopted by the National Association of Insurance Commissioners in September 1987).

(m) Revision of amended NAIC Model Regulation and amended Federal model standards; effective dates; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on December 13, 1989, the National Association of Insurance Commissioners (in this subsection and subsection (n) of this section referred to as the “Association”) revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) of this section and adopted on September 29, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) of this section) as revised by the Association in accordance with this paragraph (in this subsection
and subsection (n) of this section referred to as the “revised NAIC Model Regulation”).

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) of this section referred to as “revised Federal model standards”) for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n) of this section)—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a) of this section,

(B) no certification made pursuant to subsection (a) of this section shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A) of this section,

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(A) or (2)(B) (as the case may be).

(a) Transition compliance with revision of NAIC Model Regulation and Federal model standards

(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) of this section only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) of this section only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term “transition deadline” means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is—

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition to the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term “qualifying medicare supplemental policy” means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before December 13, 1989.

(4)(A) The date specified in this paragraph for a policy issued in a State is—

(i) the first date a State adopts, after December 13, 1989, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B), whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) of this section unless each individual who is entitled to benefits under this subchapter and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

(A) the changes in benefits under this subchapter effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and
(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before December 13, 1989, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) of this section unless the insurer—

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of December 13, 1989, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(o) Requirements of group benefits; core group benefits; uniform outline of coverage

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p) of this section.

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B) of this section, the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(p) Standards for group benefits

(1)(A) If, within 9 months after November 5, 1990, the National Association of Insurance Commissioners (in this subsection referred to as the “Association”) changes the revised NAIC Model Regulation (described in subsection (m) of this section) to incorporate—

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990.

subsection (g)(2)(A) of this section shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the “1991 NAIC Model Regulation”).

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) of this section shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the “1991 Federal Regulation”).

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC Model Regulation or 1991 Federal Regulation, but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.
(E) If benefits (including deductibles and coinsurance) under this subchapter are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide—

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies, and that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 plans described in paragraph (1)(A).

(3) The benefits under paragraph (2) shall, to the extent possible—

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of November 5, 1990; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) of this section may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards described in clauses (i) through (iii) of paragraph (1)(A) in those States that on November 5, 1990, had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholders or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (a) or (q) of this section or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 1991 NAIC Model Regulation or 1991 Federal Regulation under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

*So in original. The comma probably should be a semicolon.*
(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

(i) The benefit package classified as “F” under the standards established by such paragraph, except that it has a high deductible feature.

(ii) The benefit package classified as “J” under the standards established by such paragraph, except that it has a high deductible feature.

(B) For purposes of subparagraph (A), a high deductible feature is one which—

(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

(C) The amount specified in this subparagraph—

(i) for 1998 and 1999 is $1,500, and

(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year.

If any amount determined under clause (i) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(q) Guaranteed renewal of policies; termination; suspension

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and—

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual medicare supplemental policy which

(at the option of the certificateholder)—

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under subchapter XIX of this chapter, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) of this section as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under subchapter XIX of this chapter, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such subchapter.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph or paragraph (6) is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 426(b) of this title and is covered under a group health plan (as defined in section 1395y(b)(1)(A)(v) of this title). If such suspension occurs and if the policyholder or certificate holder loses coverage under the
group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(8)(A)(ii) of this section as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.

(4) Required ratio of aggregate benefits to aggregate premiums

(A) A medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C) of this section) in any State unless—

(1) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectations required under subparagraph (A), treating policies of the same type as a single policy for each standard package.

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C) of this section, the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate. In the case of a policy issued before the date specified in subsection (p)(1)(C) of this section, paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this section, the refund or credit required under paragraph (1)(B) applies to a policy issued as a result of the solicitation of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies; and

(E) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificate holder for credits required under such paragraph.

(s) Coverage for pre-existing conditions

(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance
or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B of this subchapter.

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the period of creditable coverage (as defined in section 300gg(c) of this title) of—

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) less than 6 months, if the policy excludes benefits based on a pre-existing condition, the policy shall reduce the period of any pre-existing condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 300gg(a)(3) of this title.

33(A) The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy.

in the case of an individual described in subparagraph (B) who, subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the applications for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this subchapter and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of this subchapter, and there are circumstances permitting discontinuance of the individual’s election of coverage under such plan.

(iii) The individual is enrolled with an eligible organization under a contract under section 1395mm of this title, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1395l(a)(1)(A) of this title, or with an organization under a policy described in subsection (t) of this section, such enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under the first sentence of section 1395w–21(e)(4) of this title.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

(I) the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer’s behalf) materially misrepresented the policy’s provisions in marketing the policy to the individual.

(v) The individual—

(I) was enrolled under a medicare supplemental policy under this section, and

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of this subchapter, any eligible organization under a contract under section 1395mm of this title, any similar organization operating under demonstration project authority, any PACE provider under section 1395eee of this title, or any policy described in subsection (t) of this section, and
(III) the subsequent enrollment under sub-
clause (II) is terminated by the enrollee dur-
ing any period within the first 12 months of
such enrollment (during which the enrollee
is permitted to terminate such subsequent
enrollment under section 1395w–2(6)(e) of this
title).

(vi) The individual, upon first becoming eli-
gible for benefits under part A of this sub-
chapter at age 65, enrolls in a Medicare+Choice
plan under part C of this subchapter or
in a PACE program under section 1395secc of
this title, and disenrolls from such plan or
such program by not later than 12 months
after the effective date of such enrollment.

(C)(i) Subject to clauses (ii) and (iii), a medi-
care supplemental policy described in this sub-
paragraph is a medicare supplemental policy
which has a benefit package classified as “A”,
“B”, “C”, or “F” under the standards estab-
lished under subsection (p)(2) of this section.

(ii) Only for purposes of an individual de-
scribed in subparagraph (B)(vi), a medicare
supplemental policy described in this subpar-
graph is the same medicare supplemental policy
referred to in such subparagraph in which the indi-
vidual was most recently previously enrolled, if
available from the same issuer, or, if not so avai-
lable, a policy described in clause (i).

(iii) Only for purposes of an individual de-
scribed in subparagraph (B)(vi), a medicare sup-
plemental policy described in this subparagraph
shall include any medicare supplemental policy.

(iv) For purposes of applying this paragraph in
the case of a State that provides for offering of
benefit packages other than under the classifica-
tion referred to in clause (i), the references to
benefit packages in such clause are deemed refer-
cences to comparable benefit packages offered
in such State.

(D) At the time of an event described in sub-
paragraph (B) because of which an individual
ceases enrollment or loses coverage or benefits
under a contract or agreement, policy, or plan,
the organization that offers the contract or
agreement, the insurer offering the policy, or
the administrator of the plan, respectively, shall
notify the individual of the rights of the individ-
ual under this paragraph, and obligations of is-
uers of medicare supplemental policies, under
subparagraph (A).

(E)(i) An individual described in subparagraph
(B)(ii) may elect to apply subparagraph (A) by
substituting, for the date of termination of en-
rollment, the date on which the individual was
notified by the Medicare+Choice organization of
the impending termination or discontinuance of
the Medicare+Choice plan it offers in the area
in which the individual resides, but only if the in-
dividual disenrolls from the plan as a result of
such notification.

(ii) In the case of an individual making such
an election, the issuer involved shall accept the
application of the individual submitted before
the date of termination of enrollment, but the
coverage under subparagraph (A) shall only be-
come effective upon termination of coverage
under the Medicare+Choice plan involved.

(4) Any issuer of a medicare supplemental pol-
icy that fails to meet the requirements of this
subsection is subject to a civil money penalty of
not to exceed $5,000 for each such failure. The
provisions of section 1320a–7a of this title (other-
ly than the first sentence of subsection (a) and
other than subsection (b)) shall apply to a civil
money penalty under the previous sentence in
the same manner as such provisions apply to a
penalty or proceeding under section 1320a–7a(a)
of this title.

(6) Medicare select policies

(1) If a medicare supplemental policy meets
the 1991 NAIC Model Regulation or 1991 Federal
Regulation and otherwise complies with the re-
quirements of this section except that benefits
under the policy are restricted to items and
services furnished by certain entities (or re-
duced benefits are provided when items or serv-
ces are furnished by other entities), the policy
shall nevertheless be treated as meeting those
standards if—

(A) full benefits are provided for items and
services furnished through a network of enti-
ties which have entered into contracts or
agreements with the issuer of the policy;

(B) full benefits are provided for items and
services furnished by other entities if the serv-
ces are medically necessary and immediately
required because of an unforeseen illness, in-
jury, or condition and it is not reasonable
given the circumstances to obtain the services
through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements
for an ongoing quality assurance program for
items and services furnished through the net-
work;

(E)(i) the issuer of the policy provides to
each enrollee at the time of enrollment an ex-
planation of (I) the restrictions on payment
under the policy for services furnished other
than by or through the network, (II) out of
area coverage under the policy, (III) the pol-
icy’s coverage of emergency services and ur-
gently needed care, and (IV) the availability of
a policy through the entity that meets the
standards in the 1991 NAIC Model Regulation
or 1991 Federal Regulation without reference
to this subsection and the premium charged
for such policy, and

(ii) each enrollee prior to enrollment ac-
knowledges receipt of the explanation pro-
vided under clause (i); and

(F) the issuer of the policy makes available
to individuals, in addition to the policy de-
scribed in this subsection, any policy (other-
wise offered by the issuer to individuals in the
State) that meets the standards in the 1991
NAIC Model Regulation or 1991 Federal Regu-
lation and other requirements of this section
without reference to this subsection.

(2) If the Secretary determines that an issuer
of a policy approved under paragraph (1)—

(A) fails substantially to provide medically
necessary items and services to enrollees seek-
ing such items and services through the issu-
er’s network, if the failure has adversely af-
fected (or has substantial likelihood of ad-
versely affecting) the individual,

(B) imposes premiums on enrollees in excess
of the premiums approved by the State,
(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or
(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

the issuer is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) of this section to determine whether items and services furnished to individuals entitled to benefits under this subchapter and under that policy are not allowable under section 1395y(a)(1) of this title. Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1395u(b) of this title shall apply to the entity.

(u) Additional rules relating to individuals enrolled in MSA plans and in private fee-for-service plans

(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1395w–21 of this title an election of an MSA plan or a Medicare+Choice private fee-for-service plan.

(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(ii) A policy of insurance to which substantially all of the coverage relates to—

(I) liabilities incurred under workers’ compensation laws,

(II) tort liabilities,

(III) liabilities relating to ownership or use of property, or

(IV) such other similar liabilities as the Secretary may specify by regulations.

(iii) A policy of insurance that provides coverage for a specified disease or illness.

(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.


REFERENCES IN TEXT

Parts A and B of this subchapter, referred to in subsecs. (d)(3)(a)(i), (vi)(i), (viii)(i), (b)(i) and (n)(2)(a), and (3)(b)(vi), are classified to sections 1395c et seq. and 1395 et seq., respectively, of this title.

Section 171(m) of the Social Security Act Amendments of 1984, referred to in subsecs. (d)(3)(a)(ix)(vi)(iv), and (r)(1), (2)(a), is section 171(m) of Pub. L. 103–432, title i, oct. 31, 1994, 108 stat. 4452, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (g)(1), is section 603(c) of Pub. L. 98–21, title vi, Apr. 20, 1983, 97 stat. 168, which was not classified to the Code, and was repealed by Pub. L. 105–33, title iv, §4003(d), aug. 5, 1997, 111 stat. 556, subject to transition provisions.

Section 2355 of the Deficit Reduction Act of 1984, referred to in subsec. (g)(1), is section 2355 of Pub. L. 98–369, div. b, title iii, July 18, 1984, 98 Stat. 1103, which is not classified to the Code.

Section 912(b) of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (g)(1), is section 912(b) of Pub. L. 101–508, title ix, Oct. 21, 1990, 104 stat. 2062, which was not classified to the Code, and was repealed by Pub. L. 105–33, title iv, §4093(d), aug. 5, 1997, 111 stat. 550, subject to transition provisions.


Part C of this subchapter, referred to in subsec. (s)(3)(b)(ii), (v)(iii), (vi), is classified to section 1395w–21 et seq. of this title.

AMENDMENTS

1999—Subsec. (g)(1). pub. l. 106–113, §1000(a)(6) (title iii, §321(k)(13)), struck out “or after “; but does not include “.

Subsec. (q)(5)(C). Pub. L. 106–170, §205(a)(1), inserted “or paragraph (6)” after “this paragraph”.  

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Subsec. (s)(3)(A). Pub. L. 106–113, §1000(a)(6) [title V, §561(a)(2)(A)], inserted “, subject to subparagraph (E),” after “the individual is otherwise entitled in subparagraph (B) who” in concluding provisions.


1998—Subsec. (t)(6). Pub. L. 105–362 struck out par. (6) which read as follows: “The Secretary shall report to the Congress in March 1998 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).”


Subsec. (d)(3)(A)(i)(II). Pub. L. 105–33, §4003(a)(1)(B), inserted “or in the case of an individual electing a Medicare+Choice plan, a Medicare supplemental policy with knowledge that such policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy” before comma at end.

Subsec. (d)(3)(A)(ii)(III). Pub. L. 105–33, §4003(c), inserted “, a policy described in clause (v),” after “Medicare supplemental policy”.


Subsec. (g)(1). Pub. L. 105–33, §4003(a)(3), inserted “or a Medicare+Choice plan or” after “does not include” the first place appearing.

Pub. L. 105–33, §4002(2)(B), struck out “,” during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995,” after “Omnibus Budget Reconciliation Act of 1986, or”.

Subsec. (p)(2)(C). Pub. L. 105–33, §4032(a)(1), inserted before period at end “plus 2 plans described in paragraph (1)(A)”.


Subsec. (s)(2)(B). Pub. L. 105–33, §4032(b)(1), substituted “subparagraphs (C) and (D)” for “subparagraph (C)”.


Subsec. (d)(3)(C). Pub. L. 104–191, §271(b)(1), substituted “with respect to” for “with respect to (i)” and struck out before period at end “, (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(II) (other than a medicare supplemental policy to an individual entitled to any medical assistance under subchapter XIX of this chapter) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this subchapter, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual”.

Subsec. (d)(3)(D). Pub. L. 104–191, §271(c)(2), struck out subparagraph (D) which provided for development of statements for various types of health insurance policies sold or issued to persons entitled to health benefits under this subchapter regarding extent to which benefits payable under those policies duplicate benefits under this subchapter.

1994—Subsec. (a)(2). Pub. L. 103–432, §171(c)(1)(B), in closing provisions substituted “on and after the effective date of the NAIC or Federal standards with respect to the policy”.


Subsec. (b)(1). Pub. L. 103–432, §171(e)(2), substituted “subsection (F)” for “subsection (F)” in last sentence.

Pub. L. 103–432, §171(c)(4), substituted “the Secretary determines” for “the the Secretary determines” in introductory provisions.


Pub. L. 104–191, §271(c)(2), inserted “, “compliance, information regarding:””.

Pub. L. 104–191, §271(c)(2), inserted “, “compliance, information regarding:””.

Pub. L. 104–191, §271(c)(2), inserted “, “compliance, information regarding:””.

Pub. L. 105–33, §4003(b), added subsec. (u).

1990 Amendment notes below.

Pub. L. 103–432, §171(d)(1)(D), struck out at end “This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section.”

Pub. L. 103–432, §171(d)(1)(C), designated third sentence as cl. (ii), substituted “clause (i) with respect to the sale of a medicare supplemental policy” for “the previous standards and requirements” in “fail to meet the standards”, “compliance, information regarding:” for “compliance, and information regarding”, and “Commissioners may specify” for “Commissioners, may specify.”


Pub. L. 103–432, §171(d)(1)(A), designated first sentence as cl. (i) and amended it generally. Prior to
amendment, first sentence read as follows: “It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this subchapter or subchapter XIX of this chapter).”

Subsec. (d)(3)(B)(i)(II). Pub. L. 103–432, §171(a)(2)(A), struck out “65 years of age or older” before “may be eligible”.

Subsec. (d)(3)(B)(i)(II). Pub. L. 103–432, §171(d)(2)(B), (C), substituted “has a medicare supplemental policy” for “has another medicare supplemental policy” and “sale of a medicare supplemental policy” for “sale of such a policy”.


Subsec. (d)(3)(C). Pub. L. 103–432, §171(a)(5)(A), substituted “‘the sale or issuance of a group policy’ for ‘the selling of a group policy’ and added clts. (ii) and (iii).”


Subsec. (d)(4)(D). Pub. L. 103–432, §171(k)(1), struck out before period at end “, if such policy expires not more than 12 months after the date on which the duplicate copy is mailed”.


Subsec. (g)(1). Pub. L. 103–432, §171(k)(1), substituted “an eligible organization (as defined in section 1395mm(g)(2)(A) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 693(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 912(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1985, any other organization if the policy or plan provides benefits pursuant to an agreement under section 1395mm(a)(1)(A) of this title for a health maintenance organization or other direction service organization which offers benefits under this subchapter, including such services under a contract under section 1395mm of this title or an agreement under section 1395m of this title”.

Subsec. (g)(2)(B). Pub. L. 103–432, §171(c)(3), substituted “Secretary” for “Panel”.


Subsec. (p)(1)(A). Pub. L. 103–432, §171(a)(2)(A), in introductory provisions, substituted “changes the revised NAIC Model Regulation (described in subsection (m) of this section) to incorporate” for “promulgate”, and in closing provisions, struck out “(such limitations, language, definitions, format, and standards referred to collectively in this subsection as ‘NAIC standards’),” before “subsection (g)(2)(A) of this section” and substituted “were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘1991 NAIC Model Regulation’)” for “‘1991 NAIC Model Regulation’”.

Subsec. (p)(1)(B). Pub. L. 103–432, §171(a)(2)(B), substituted “‘make the changes in the revised NAIC Model Regulation promulgate NAIC standards’, ‘a regulation’ for ‘limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph’”.


Subsec. (p)(4)(A)(i). Pub. L. 103–432, §171(a)(2)(F), inserted “or paragraph (6)” after “subparagraph (B)”.

Subsec. (p)(8). Pub. L. 103–432, §171(a)(2)(H), substituted “described in clauses (i) through (iii) of paragraph (1)(A)” for “‘in regard to the limitation of benefits described in paragraph (4)”.


Subsec. (p)(10). Pub. L. 103–432, §171(a)(2)(L), substituted “consistent with paragraph (1)(A)” for “consistent with this subsection”.

Subsec. (q)(2). Pub. L. 103–432, §171(b)(1), substituted “paragraph (4)” for “paragraph (2)”.

Subtitle B. Pub. L. 103–432, §171(b)(2), substituted “issuer of the replacement policy” for “the succeeding issuer”.

Subtitle C. Pub. L. 103–432, §171(c)(1), made technical amendment to the reference to subchapter XIX of this chapter to correct reference to corresponding provision of original act.

Subtitle C. Pub. L. 103–432, §171(c)(4), made technical amendment to the reference to subchapter XIX of this chapter to correct reference to corresponding provision of original act.
on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.


Pub. L. 103–432, §171(e)(1)(B), inserted “for periods after the effective date of these provisions” after “the policy can be expected”.

Subsec. (r)(1)(B). Pub. L. 103–432, §171(e)(1)(D), inserted before period at end “‘treating policies of the same type as a single policy for each standard package’”.

Subsec. (r)(2)(A). Pub. L. 103–432, §171(e)(1)(F)–(I), substituted “‘by standard package’” for “‘by policy number’” in first sentence and “‘until 12 months following issuance’” for “‘with respect to the first 2 years in which it is in effect’” in second sentence, struck out “‘in order to apply paragraph (1)(B) to the first 2 years in which policies are effective’” after “may be appropriate” in third sentence, and inserted at end “‘In the case of a policy issued before the date specified in subparagraph (p)(1)(C) of this section, paragraph (1)(B) shall not apply until 1 year after the dates specified in section 171(m)(4) of the Social Security Act Amendments of 1994.’”


Subsec. (r)(6)(A). Pub. L. 103–432, §171(e)(1)(L), substituted “‘fails to provide refunds or credits as required in paragraph (1)(B)’” for “‘issues a policy in violation of the loss ratio requirements of this subsection’” and “‘policy issued for which such failure occurred’” for “‘such violation’”.

Subsec. (s)(2)(B). Pub. L. 103–432, §171(e)(1)(M), substituted “‘to the policyholder or, in the case of a group policy, to the certificate holder’” for “‘to policyholders’”.

Subsec. (s)(2)(A). Pub. L. 103–432, §171(g)(1)(2), substituted “‘in the case of an individual for whom an application is submitted prior to or for’” for “‘for which an application is submitted and “as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B’” for “‘in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B’”.

Subsec. (s)(2)(B). Pub. L. 103–432, §171(g)(3), substituted “‘before the policy became effective’” for “‘before it became effective’”.

Subsec. (s)(3)(A). Pub. L. 103–432, §171(h)(1)(A), (B), substituted “‘a Medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation’” for “‘if a policy meets the NAIC standards’”.


Subsec. (t)(2). Pub. L. 103–432, §171(h)(1)(E), inserted the “‘issuers’” before “‘subject to a civil money penalty’” in concluding provisions.


Subsec. (a). Pub. L. 101–508, §4353(a)(2), designated existing provisions as par. (1) and added par. (2).


Subsec. (b)(1). Pub. L. 101–508, §4353(b)(5)(d), inserted at end “‘The report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards in this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.’”

Pub. L. 101–508, §4353(b)(1), (2), substituted “‘the Secretary for’” for “‘Supplemental Health Insurance Panel (established under paragraph (2))’” in introductory provisions and for “‘the Panel’” in concluding provisions.

Pub. L. 101–508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103–432, §160(d)(4), which directed the amendment of third sentence of par. (1) by striking out “‘(k)(4),’” was executed by making the deletion after “‘subsections (k)(3),’” in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(1)(A). Pub. L. 101–508, §4353(b)(2)(A), inserted before semicolon at end “‘except as otherwise provided by subparagraph (H)’”.

Pub. L. 101–508, §4353(b)(3), inserted “‘and enforcement’” after “‘application’”.


Subsec. (b)(1)(C). Pub. L. 101–508, §4353(b), substituted for “semiconductor at end ‘‘and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for such policy issued or sold in the State is maintained and made available to interested persons’’”.


Subsec. (b)(1)(G). Pub. L. 101–508, §4355(c), which directed amendment of par. (1) by adding at the end thereof a new subpar. (G), was executed by adding the new subpar. (G) immediately after subpar. (F) to reflect the probable intent of Congress.


Subsec. (b)(2). Pub. L. 101–508, §4353(b)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

“(A) There is hereby established a panel (hereinafter in this section referred to as the ‘Panel’) to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the Secretary and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

“(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

“(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

“(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph.

“(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5.”

Subsec. (c). Pub. L. 101–508, §4357(a)(1), inserted “‘and the requirement described in subsection (e) of this section’” after “‘paragraph (3)’” in introductory provisions.

Pub. L. 101–508, §4355(a)(2), struck out at end “‘For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.’”

Subsec. (c)(1). Pub. L. 101–508, §4358(b)(1), inserted before semicolon at end “‘except as otherwise provided by subsection (t) of this section’”.

Page 2191 TITLE 42—THE PUBLIC HEALTH AND WELFARE §1395ss
Subsec. (c)(2). Pub. L. 101–508, §4355(a)(1), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies.”


Subsec. (d)(3)(A). Pub. L. 101–508, §4356(a)(1), substituted “It is unlawful for a person to sell or issue” for “substantially duplicates health benefits”, “Whoever violates the previous sentence shall be fined”, “(subject to subsection (k)(3) of this section, for so long as” for “(for so long as)” in concluding provisions.

Subsec. (b)(1)(B). Pub. L. 101–360, §221(b)(1), substituted “(A), (B), and (C)” for “(A) and (B)”.

Subsec. (b)(1)(D). Pub. L. 101–360, §221(b)(2), redesignated former subpar. (C) as (D) and vice versa.

Subsec. (b)(2)(A). Pub. L. 101–360, §221(b), substituted “appointed by the Secretary” for “appointed by the President”.

Subsec. (c). Pub. L. 101–360, §221(e), added par. (3).


Subsec. (c)(1)(A). Pub. L. 101–234, §203(a)(1)(B)(i), inserted “for such purposes” for “for purposes of this paragraph, benefits which are payable to or on behalf of an individual.”

Subsec. (c)(1)(A). Pub. L. 101–234, §203(a)(1)(B), as amended, substituted “Subject to subsection (k)(3) of this section, such” for “Such”.

Subsec. (c)(3). Pub. L. 101–360, §221(e), added par. (3).


Subsec. (c)(3)(A). Pub. L. 101–360, §411(i)(1)(C)(i), substituted “claim form” for “claims form” in two places and “such notice” for “such claims form”.


Subsec. (d). Pub. L. 101–360, §428(b)(1), substituted “shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act” for “shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both” in pars. (1), (2), (3), and (4).


Subsec. (e). Pub. L. 101–360, §221(c), designated existing provision as par. (1) and added pars. (2) and (3).

Subsec. (k). (i). Pub. L. 101–360, §221(c)(2), added subsec. (k) and (l).

1987—Subsec. (b)(1)(B). Pub. L. 100–203, §4081(b)(1)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “includes a requirement equal to or more stringent than the requirement described in subsection (c)(2) of this section; and”.
CHANGE OF NAME

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by section 1000(a)(6) [title III, § 321(k)(13), (14)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106-113, set out as a note under section 1395f of this title.

Amendment by section 1000(a)(6) [title V, § 501(a)(2)] of Pub. L. 106-113 applicable to notices of impending terminations or discontinuances made on or after Nov. 29, 1999, see section 1000(a)(6) [title V, § 501(d)(1)] of Pub. L. 106-113, set out as a note under section 1395w-21 of this title.

Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 536(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-391, provided that: "The amendments made by this section [amending this section] shall apply to terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT
Section 4002(j)(2) of Pub. L. 105-33 provided that the amendment made by that section is effective Jan. 1, 1999.

Section 4032(b) of Pub. L. 105-33 provided that:

"(1) GUARANTEED ISSUE.—The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1996.

"(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—

The amendment made by subsection (b) [amending this section] shall apply to policies issued on or after July 1, 1996.

"(3) CONFORMING AMENDMENT.—The amendment made by subsection (c) [amending this section] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191]."

Section 4032(b) of Pub. L. 105-33 provided that:

"(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall take effect the date of the enactment of this Act [Aug. 5, 1997].

"(2) TRANSITION.—The provisions of section 4031(e) [set out as a note below] shall apply with respect to this section in the same manner as they apply to section 4031 [amending this section and enacting provisions set out as notes below]."

EFFECTIVE DATE OF 1996 AMENDMENT
Section 271(d) of Pub. L. 104-191 provided that:

"(1) Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508].

"(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A)(vi) of this section], as added by subsection (a), shall only apply to individuals applying for—

"(i) a health insurance policy as described in section 1882(d)(3)(A)(vi) of such Act (as added by subsection (a)), after the date of the enactment of this Act [Aug. 21, 1996], or

"(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

"(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act (as in effect before the date of the enactment of this Act), without the revision specified in such clause."

EFFECTIVE DATE OF 1994 AMENDMENT
Section 171(l) of Pub. L. 103-432 provided that: "The amendments made by this section [amending this section and sections 1320c-3, 1395b-2, and 1395b-4 of this title, repealing section 1395ff of this title, and enacting and amending provisions set out as notes below] shall be effective as if included in the enactment of OBRA–1990 [Pub. L. 101-508]; except that—

"(1) the amendments made by subsection (d)(1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994], but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] (for an action occurring after the effective date of the amendments made by section 4354 of OBRA–1990 [see section 4354(c) of Pub. L. 101-508, set out as an Effective Date of 1990 Amendment note below] and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act (as amended by this section); and

"(2) the amendments made by subsection (d)(2)(A) [amending this section] and by subparagraphs (A), (B), and (E) of subsection (e)(1) [amending this section] shall be effective on the date specified in subsection (m)(4) [set out as a note below]; and

"(3) the amendment made by subsection (g)(2) [amending this section] shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(c)(2) of the Social Security Act [subsec. (c)(2) of this section, for effective date see section 4357(b) of Pub. L. 101-508, set out as an Effective Date of 1990 Amendment note below] and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995.

EFFECTIVE DATE OF 1990 AMENDMENT
Section 4353(d)(2) of Pub. L. 101-508 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to policies issued, or caused to be mailed, on and after July 1, 1991."

Section 4354(c) of Pub. L. 101-508 provided that: "The amendments made by this section [amending this section] shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4355(d) of Pub. L. 101-508, as amended by Pub. L. 103-432, title I, § 171(e)(3), Oct. 31, 1994, 108 Stat. 4449, provided that: "The amendments made by this section [amending this section] shall apply to policies issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act [subsec. (p)(1)(C) of this section]) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act.

Section 4356(b) of Pub. L. 101-508, as amended by Pub. L. 103-432, title I, § 171(f)(2), Oct. 31, 1994, 108 Stat. 4449, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date specified in section 1882(p)(1)(C) of the Social Security Act [subsec. (p)(1)(C) of this section]."

Section 4357(b) of Pub. L. 101-508 provided that: "The amendments made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Nov. 5, 1990]."
Amendment by section 4358(a), (b)(1), (2) of Pub. L. 101–508 only applicable in 15 States (as determined by Secretary of Health and Human Services) and such other States as elect such amendment to apply to them, and during the 6½-year period beginning with 1992, with such amendment to remain in effect beyond the 6½-year period unless the Secretary makes certain determinations, see section 1320(c)(1) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

Effective Date of 1989 Amendment
Section 203(e) of Pub. L. 101–234 provided that: "The provisions of this section [amending this section, enacting provisions set out as notes under sections 1395b–2 and 1395mm of this title, and amending provisions set out as a note under this section] shall take effect on January 1, 1990, except that the amendment made by subsection (d) [amending provisions set out as an Effective Date of 1986 Amendment note under this section] shall be effective as if included in the enactment of MCCA [Pub. L. 100–360]."

Effective Date of 1988 Amendment

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]."

"(2) The amendments made by subsections (a) and (b) [amending this section] shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act [subsec. (k)(1)(B) or (k)(2)(B) of this section] (as added by subsection (d) of this section)."

"(3) The amendment made by subsection (e) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

"(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act [subsec. (b)(2) of this section]) by not later than 90 days after the date of the enactment of this Act [July 1, 1988]."

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(1), (B), (C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA: Effective Date note under section 106 of Title I, General Provisions. Amendment by section 428(b) of Pub. L. 100–360 effective as of 1988, applicable only with respect to violations occurring on or after such date, see section 428(c) of Pub. L. 100–360, set out as an Effective Date note under section 1320–10 of this title.

Effective Date of 1987 Amendments

"(A) The amendments made by subsection (b) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989 (or, if applicable, the date established under subparagraph (B))."

"(B) In the case of a State which the Secretary of Health and Human Services identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to be changed to meet the requirements of section 1862(c)(5) of the Social Security Act [subsec. (c)(5) of this section], and

"(ii) having a legislature which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered or which has not enacted such legislation before July 1, 1988, the date specified in this subparagraph is the first day of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered, Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

Effective Date
Section 507(b) of Pub. L. 96–253 provided that: "The amendment made by this section [amending this section] shall become effective on the date of the enactment of this Act [June 9, 1980], except that the provisions of paragraph (4) of section 1862(d) of the Social Security Act [subsec. (d)(4) of this section] (as added by this section) shall become effective on July 1, 1982."

Study of Medicare Policies
Pub. L. 106–113, div. B, §1000(a)(6) [title V, §553(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

"(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘Comptroller General’) shall conduct a study at the request of the Secretary of Health and Human Services described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))."

"(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

"(A) The level of coverage provided by each type of medicare supplemental policy.

"(B) The current enrollment levels in each type of medicare supplemental policy.

"(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65%.

"(D) The number and type of medicare supplemental policies offered in each State.

"(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

"(2)(3) REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

Conforming Benefits to Changes in Terminology for Hospital Outpatient Department Cost Sharing
Section 4031(f) of Pub. L. 105–33 provided that: "For purposes of apply [sic] section 1882 of the Social Security Act (42 U.S.C. 1395s) and regulations referred to in subsection (e) [set out as a note above], copayment amounts provided under section 1833(t)(5) of such Act [section 1395s(t)(5) of this title] with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services."

Transition Provisions
Section 4031(e) of Pub. L. 105–33 provided that:

"(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a transition [sic] to conform to the changes made by this subsection, the State regulatory program to the changes made by this subsection [amending this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1862 of the Social Security Act [this section] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act [Aug. 5, 1997], and
Model Regulation relating to section 1882 of the Social Security Act [this section] (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 [Public Law 103-432] [set out as a note below] and as modified pursuant to section 1882(d)(3)(A)(VI) of the Social Security Act [subsec. (d)(3)(A)(VI) of this section], as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 [Public Law 104-191] to conform to the amendments made by this section [amending this section]), such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC \[model regulation\] and the 1991 NAIC Model Regulation) for the purposes of such section.

"(3) \[SECRETARY STANDARDS—\]—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

"(4) \[DATE SPECIFIED—\]—

\[(A) IN GENERAL—\]—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

\[(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or
\[(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.
\]

\[(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED—\]—In the case of a State which the Secretary identifies as—

\[(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but
\[(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,
\]

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Section 271(c) of Pub. L. 104-191 provided that:

"(A) PENALTIES—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] for any act or omission that occurred during the transition period (as defined in paragraph (4)) or that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

"(B) LIMITATION ON LEGAL ACTION—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

\[(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and
\[(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).
\]

"(3) \[DISCLOSURE CONDITION—\]—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(1)(C) of the Social Security Act Amendments of 1994 [Pub. L. 103-432, set out below] and before the end of the 30-day period beginning on the date of the enactment of this Act [Aug. 21, 1996], paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act as so in effect before the date of the enactment of this Act.

"(4) \[TRANSITION PERIOD—\]—In this subsection, the term ‘transition period’ means the period beginning on November 30, 1991, and ending on the date of the enactment of this Act.

\[APPLICABILITY OF DISCLOSURE REQUIREMENT—\]—

Section 171(m)(3)(C) of Pub. L. 103-432 provided that:

"The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [subsec. (d)(3)(C)(ii) of this section] shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act."

\[STATE REGULATORY PROGRAMS—\]—

Section 171(m) of Pub. L. 103-432 provided that:

"(1) \[IN GENERAL—\]—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section and sections 1320c-3, 1365b-2, and 1365v-4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes under this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [this section] due solely to failure to make such change until the date specified in paragraph (4).

\[(2) NAIC STANDARDS—\]—If, within 6 months after the date of the enactment of this Act (Oct. 31, 1994), the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with ‘unless’, such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

"(3) \[SECRETARY STANDARDS—\]—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

"(4) \[DATE SPECIFIED—\]—

\[(A) IN GENERAL—\]—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

\[(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or
\[(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.
\]

\[(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED—\]—In the case of a State which the Secretary identifies as—

\[(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this Act, but
\[(ii) having a legislature which is not scheduled
\]

such legislation may be considered, to meet in 1996 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

\[ADDITIONAL LEGISLATIVE ACTION REQUIRED—\]—If, within 6 months after the date of the enactment of this Act (Oct. 31, 1994), the National Association of Insurance Commissioners (in this subsection referred to as the ‘NAIC’) modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with ‘unless’, such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.
§ 1395tt. Hospital providers of extended care services

(a) Hospital facility agreements; reasonable costs of services

(1) Any hospital which has an agreement under section 1395cc of this title may (subject to subsection (b) of this section) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this subchapter to the contrary, under this section shall be deemed to be a separate regular session of the State legislature."

(b) Eligible facilities

The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g) of this section, the hospital is located in a rural area and has less than 100 beds.

(c) Terms and conditions of facility agreements

An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1395ccc of this title and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1395ccc of this title; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1395ccc of this title. A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Post-hospital extended care services

Any agreement with a hospital under this section shall provide that payment for services which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1395ccc of this title; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this subchapter (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1395ccc of this title.

(e) Reimbursement for routine hospital services

During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including this subchapter, subchapter XIX of this chapter, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine this subchapter reimbursement for routine hospital services.

(f) Conditions applicable to skilled nursing facilities

A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1395l-3 of this title. Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services.

has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.'
when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) Agreements on demonstration basis

The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1) of this section, if the hospital otherwise meets the requirements of this section.


AMENDMENTS

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title IV, §4005(b)(1)], struck out “‘other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e)(2)(A) of this title’” after “Any hospital”.

Subsec. (b). Pub. L. 106–113, §1006(a)(6) [title IV, §4005(b)(2)], struck out “‘(1) except as provided under subsection (g) of this section, the hospital is located in a rural area and has less than 100 beds, and

“(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.’.”

1997—Subsec. (c). Pub. L. 106–113, §1006(a)(6) [title IV, §4005(b)(2)], struck out “‘, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title before the period at end of first sentence.’”

Subsec. (d). Pub. L. 106–113, §1006(a)(6) [title IV, §4005(b)(2)], struck out “‘(1) except as provided under section 1395x(e) of this title and

“(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.’.”


“‘(2) the hospital is a hospital that

‘‘(A) has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title before the period at end of first sentence and

‘‘(B) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.’”


“(2) the hospital is a hospital that

‘‘(A) has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title before the period at end of first sentence and

‘‘(B) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.’”


“(2) the hospital is a hospital that

‘‘(A) has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title before the period at end of first sentence and

‘‘(B) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located.’”

1989—Subsecs. (d)(1), (f). Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(6), 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. (d)(3). Pub. L. 100–360, §411(b)(4)(D), inserted before period at end “‘except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph.’”


Subsec. (d). Pub. L. 100–203, §4005(b)(2), designated existing provisions as par. (1) and added pars. (2) and (3).


Effective Date of 1999 Amendment

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §4005(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, provided that: “The amendments made by this section [amending this section] take effect on the date that is the first day after the expiration of the transition period under section 1388(e)(2)(E) of the Social Security Act (42 U.S.C. 1395y(aa)(2)(E)) for payments for covered skilled nursing facility services under the medicare program.”

Effective Date of 1997 Amendment

Amendment by Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1996, see section 4323(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Effective Date of 1990 Amendment

Section 4008(j)(4) of Pub. L. 101–508 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after October 1, 1990.”

Effective Date of 1989 Amendment


Effective Date of 1988 Amendments

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(6) of 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 fur-
lished 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.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(4)(D), (b)(1)(C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title I, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Section 4005(b)(4) of Pub. L. 100–203 provided that: "The amendments made by this section (and (2) [amending this section] shall apply to agreements under section 1393 of the Social Security Act (this section) entered into after March 31, 1986.

Amendment by section 4201(d)(3) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1980, without regard to whether regulations to implement such amendment are promulgated by such date, except as otherwise specifically provided in section 1395–3 of this title, see section 1204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395–3 of this title.

EFFECTIVE DATE

Section 904(d) of Pub. L. 96–499 provided that: "The amendments made by this section (enacting this section and section 1396f of this title) shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980]."

HOLD HARMLESS FOR AMENDMENT BY PUB. L. 101–508

Section 4008(j)(2) of Pub. L. 101–508 provided that: "If, as a result of the amendment made by paragraph (1) [amending this section], the reasonable cost of routine services furnished by a hospital during a calendar year (as determined under section 1393 of the Social Security Act [this section]) is less than the reasonable cost of such services determined under such section for the previous calendar year, the reasonable cost of such services furnished by the hospital during the calendar year under such section shall be equal to the reasonable cost determined under such section for the previous calendar year."

SWING BEDS CERTIFIED PRIOR TO MAY 1, 1987

Section 4008(j)(3) of Pub. L. 101–508 provided that: "Notwithstanding the requirement of section 1383(b)(1) of the Social Security Act [subsec. (b)(1) of this section] that the Secretary may not enter into an agreement under such section with a hospital that is not located in a rural area, any agreement entered into under such section on or before May 1, 1987, between the Secretary of Health and Human Services and a hospital located in an urban area shall remain in effect."

REPORT OF HOSPITAL ADMISSIONS FOR EXTENDED CARE SERVICES

Section 4005(b)(3) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(4)(E), as added by Pub. L. 100–360, set out as a note under section 1395d of this title, as amended, set out as a note under section 1395d of this title.

REPORT ON HOSPITAL PROVIDERS OF EXTENDED CARE, SKILLED NURSING, AND INTERMEDIATE CARE SERVICES

Section 904(c) of Pub. L. 96–499 directed Secretary of Health and Human Services, within three years after Dec. 5, 1980, to submit to Congress a report evaluating programs established by the amendments made by this section (enacting this section and section 1396f of this title), including in such report an analysis of the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care services, whether such programs should be continued, the results of any demonstration projects conducted under such programs, and whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1395i–4, 1395yy, 1396f of this title.

§ 1395uu. Payments to promote closing or conversion of underutilized hospital facilities

(a) Transitional allowances; procedures applicable

Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this subchapter with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

(b) Allowable costs as transitional allowances; findings and determinations

If the Secretary finds, after consideration of an application under subsection (a) of this section, that—

(1) the hospital’s closure or conversion—
(A) is formally initiated after September 30, 1981,
(B) is expected to benefit the program under this subchapter by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and
(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and
(2) in the case of a complete closure of a hospital—
(A) the hospital is a private nonprofit hospital or a local governmental hospital, and
(B) the closure is not for replacement of the hospital,
the Secretary may include as an allowable cost in the hospital’s reasonable cost (for the purpose of making payments to the hospital under this Subchapter)
subchapter) an amount (in this section referred to as a “transitional allowance”), as provided in subsection (c) of this section.

(c) Factors determinative of transitional allowance

(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this subchapter and shall recognize—

(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital’s costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this subchapter, and

(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this subchapter; and

(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this subchapter, less any salvage value of the hospital.

(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1395x(v)(1) of this title, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1395(b) and 1395(a)(2) of this title.

(d) Hearing to review determination

A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.

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has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) Implementing regulations; notice, opportunity to be heard, etc.

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary’s satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this subchapter which shall be treated as a setoff against overpayments under subchapter XIX of this chapter, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XIX of this chapter and to which the institution or person would otherwise be entitled under this subchapter.

c) Payment to States of amounts recovered

Notwithstanding any other provision of this chapter, from the trust funds established under sections 13951 and 13951 of this title, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency’s overpayment under subchapter XIX of this chapter. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.


§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; “operating costs of inpatient hospital services” defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent; and

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)3(B) of this section).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital’s last cost reporting period prior to the hospital’s first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital’s control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term “operating costs of inpatient hospital services” includes all routine operating costs, ancillary service operating costs, and special care unit op-
(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section and other than a rehabilitation facility described in subsection (j)(1) of this section) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount, whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis shall equal the target amount; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(2)(A) Except as provided in subparagraph (B), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an "eligible hospital" means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term "trended costs" means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term "expected costs", with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before November 29, 1999, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and
§ 1395ww

hospital:

lowing shall be treated as a separate class of

aplicable percentage increase’’ shall be—

charges occurring during a fiscal year, the ‘‘ap-

section and subsection (j) of this section for dis-

increased by the applicable percentage increase

reporting period.

under subparagraph (B) for that particular cost

term ‘‘target amount’’ means, with respect to a

hospital for a particular 12-month cost reporting

period—

(i) in the case of the first such reporting pe-

period for which this subsection is in effect, the

allowable operating costs of inpatient hospital

services (as defined in subsection (a)(4) of this

section) recognized under this subchapter for

such hospital for the preceding 12-month cost

reporting period, and

(ii) in the case of a later reporting period,

the target amount for the preceding 12-month

cost reporting period,

increased by the applicable percentage increase

under subparagraph (B) for that particular cost

reporting period.

(B)(i) For purposes of subsection (d) of this

section and subsection (j) of this section for dis-

charges occurring during a fiscal year, the ‘‘ap-

licable percentage increase’’ shall be—

(I) for fiscal year 1986, 1 1/2 percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hos-

pitals located in a rural area, 1.5 percent for

hospitals located in a large urban area (as de-

fined in subsection (d)(2)(D) of this section),

and 1.0 percent for hospitals located in other

urban areas,

(IV) for fiscal year 1989, the market basket

percentage increase minus 1.5 percent for hos-

pitals located in a rural area, the market

basket percentage increase minus 2.0 percentage

points for hospitals located in a large urban

area, and the market basket percentage in-

crease minus 2.5 percentage points for hos-

pitals located in other urban areas,

(V) for fiscal year 1990, the market basket

percentage increase minus 2.0 percentage points

for hospitals located in a rural area, the market

basket percentage increase plus 0.12 per-

centage points for hospitals located in a large

urban area, and the market basket percentage in-

crease minus 0.53 percentage points for hos-

pitals located in other urban areas,

(VI) for fiscal year 1991, the market basket

percentage increase minus 2.0 percentage points

for hospitals in a large urban or other

urban area, and the market basket percentage in-

crease minus 0.7 percentage point for hos-

pitals located in a rural area,

(VII) for fiscal year 1992, the market basket

percentage increase minus 1.6 percentage points

for hospitals in a large urban or other

urban area, and the market basket percentage in-

crease minus 0.6 percentage point for hos-

pitals located in a rural area,

(VIII) for fiscal year 1993, the market basket

percentage increase minus 1.55 percentage

point for hospitals in a large urban or other

area, and the market basket percentage increase

minus 0.55 1 for hospitals located in a rural

area,

(IX) for fiscal year 1994, the market basket

percentage increase minus 2.5 percentage

points for hospitals located in a large urban or

other urban area, and the market basket percent-

age increase minus 1.0 percentage point for hos-

pitals located in a rural area,

(X) for fiscal year 1995, the market basket

percentage increase minus 2.5 percentage

points for hospitals in all areas,

(XI) for fiscal year 1996, the market basket

percentage increase minus 2.0 percentage

points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket

percentage increase minus 0.5 percentage

point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket

percentage increase minus 1.9 percentage

points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket

percentage increase minus 1.8 percentage

points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket

percentage increase minus 1.1 percentage

points for hospitals (other than sole community

hospitals) in all areas, and the market

basket percentage increase for sole community

hospitals,

(XVII) for fiscal year 2002, the market bas-

ket percentage increase minus 1.1 percentage

points for hospitals in all areas, and

(XVIII) for fiscal year 2003 and each subse-

quent fiscal year, the market basket percent-

age increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E),

the ‘‘applicable percentage increase’’ for 12-

month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket

percentage increase minus 2.0 percentage

points,

(IV) a subsequent fiscal year ending on or

before September 30, 1993, is the market bas-

ket percentage increase,

(V) fiscal years 1994 through 1997, is the mar-

ket basket percentage increase minus the ap-

plicable reduction (as defined in clause (v)(II)),

or in the case of a hospital for a fiscal year for

which the hospital’s update adjustment per-

centage (as defined in clause (v)(I)) is at least

10 percent, the market basket percentage in-

crease,

(VI) for fiscal year 1998, is 0 percent,

1 So in original. Probably should be followed by ‘‘percentage

point’’. 
(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(ii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (I).

(v) For purposes of clause (ii)(V)—

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the fiscal year exceeded the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds 2% of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed 2% of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) of this section), subject to subparagraph (I), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, and for discharges beginning on or after October 1, 1997, and before October 1, 2006, in the case of a hospital that is a medicare-dependent, small rural hospital (as
The term “target amount” means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the “base cost reporting period”) preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital’s cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B) of this section) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital’s 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(iv) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) of this section and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(O)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital’s 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for the hospital for the 12-month cost reporting period beginning
during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) of this section during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997, for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate percentage of at least 70 percent (as determined by the Secretary under subsection (d)(1)(B) of this section) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (ii)(II).

(ii)(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, the Secretary shall update such amount by a factor equal to the market basket percentage increase.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) of this section and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(i) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(4)(A)(ii) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital for discharges occurring in财政年度, 75 percent of the target amount (as defined in clause (ii));

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the "subparagraph (C) target amount") and 25 percent of the rebased target amount (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebased target amount; and

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subparagraph (C) target amount and 75 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.
(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i), in making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1986, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(1) of this section, the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospitals described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A of this subchapter on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(ii) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) of this section and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c) Payment in accordance with State hospital reimbursement control system; amount of payment; discontinuance of payments

(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under subchapter XIX of this chapter; and

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients; and

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State),
the amount of payments made under this subchapter under such system will not exceed the amount of payments which would otherwise have been made under this subchapter not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1395mm(b) of this title) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1395cc(a)(1)(G) of this title and the system provides for the exclusion of certain costs in accordance with section 1395y(a)(14) of this title (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than the basis of a diagnosis-related group or on the ground that the amount of payments made under this subchapter under such system must be less than the amount of payments which would otherwise have been made under this subchapter not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A of this subchapter) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A of this subchapter for inpatient hospital services, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this subchapter in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) under this subchapter for hospitals in the State which is less than the aggregate rate of increase in such costs under this subchapter for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of this subchapter has been approved on or before (and which is in effect as of) April 20, 1983, pursuant to section 1395b–1(a) of this title or section 222(a) of the Social Security Amendments of 1972.

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this subchapter, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this chapter) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,
(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this subchapter to hospitals under the system in an amount equal to the amount by which the payment under this subchapter under such system for such period exceeded the amount of payments which would otherwise have been made under this subchapter not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a “36-month period” is deemed a reference to a “48-month period”, and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under this subchapter to hospitals under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital’s target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital’s target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to—

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same large urban or other area) as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term “subsection (d) hospital” means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1395x(f) of this title), (ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv)(I) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990,2 (or, in the case of a hospital that, as of December 19, 1989, is located in a State operat-

2So in original. The comma probably should not appear.
ing a demonstration project under section 1395f(b) of this title, on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer, or

(ii) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1395f(b) of this title, that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before August 5, 1997), that as of August 5, 1997, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E); and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the “target percentage” is 75 percent and the “DRG percentage” is 25 percent; and

(ii) on or after October 1, 1984, and before October 1, 1985, the “target percentage” is 50 percent and the “DRG percentage” is 50 percent; and

(iii) on or after October 1, 1985, and before October 1, 1986, the “target percentage” is 45 percent and the “DRG percentage” is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the “target percentage” is 25 percent and the “DRG percentage” is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the “applicable combined adjusted DRG prospective payment rate” for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subparagraph (B)(v)(II) only, the term “principal finding of neoplastic disease” means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V58.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) adjusting for variations among hospitals and adjusting for variations in case mix among hospitals, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section) for fiscal year 1984.

(C) The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid, Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999,

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 9602(c) of the Omnibus Budget Reconciliation Act of 1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990.
(D) The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—
(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and
(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) of this section by regulation; the term "large urban area'' means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this subchapter) from hospitals in the same Metropolitan Statistical Area are made.

(E) The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) of this section for that fiscal year.

(G) For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—
(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—
(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a large urban area in the United States or that region, and
(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and
(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—
(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and
(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A)(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B) of this section.

(ii) For discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(iii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each re-
tion, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) of this section with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in another\(^3\) urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv) For discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) of this section with respect to hospitals located in the respective areas for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(B) The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C)(i) For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) of this section for that fiscal year.

(ii) For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9194 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (i)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

\(^3\)So in original. Probably should be “another”.

(D) For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. To the extent determined feasible by the Secretary, such survey shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting
factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B) for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B) of this section.

5(A)(1) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(II) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph, the term "day outlier percentage" means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2) of this section, except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(i)(II) (or, if applicable, the amount determined under paragraph (1)(A)(ii)(II)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to \( c \times ((1+r) to the nth power) - 1 \), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals 0.405. For discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, "c" is equal to 1.89;

(II) during fiscal year 1998, "c" is equal to 1.72;

(III) during fiscal year 1999, "c" is equal to 1.6;

(IV) during fiscal year 2000, "c" is equal to 1.47;

(V) during fiscal year 2001, "c" is equal to 1.54; and

(VI) on or after October 1, 2001, "c" is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located
in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) of this section shall apply for purposes of this clause.

(vi) For purposes of clause (ii)—

(I) "r" may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

(viii) Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of clauses (v) and (vi).

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of the Secretary's determination.

(iii) For purposes of this subchapter, the term "rural hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital.

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i) of this title as in effect on September 30, 1997.

(II) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges in a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i).

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C) of this section, or

(II) the amount determined under paragraph (1)(A)(iii), whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this subchapter, the term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital.

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i) of this title as in effect on September 30, 1997.
(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1395i–4(d) of this title in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) of this section to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B of this subchapter in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) For discharges occurring on or after May 1, 1986, and before October 1, 1997, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX of this chapter), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amounts determined under paragraph (1)(A)(ii)(I) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent;

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent;

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent.

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent, if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent, if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent, if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds 5 percent.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and
(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital’s patient days for such period.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(V) is the percentage determined in accordance with the following formula:

\[ \frac{P_{\text{min}}}{} \times 3 + 5.88 \]  

where “\( P \)” is the hospital’s disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, \((P - 20.2)(.65) + 5.62\), and

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, \((P - 20.2)(.7) + 5.62\), and

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, \((P - 20.2)(.8) + 5.88\), and

(d) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, \((P - 15)(.6) + 2.5\), and

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, \((P - 15)(.65) + 2.5\), and

(c) for discharges occurring on or after October 1, 1993, \((P - 15)(.65) + 2.5\),

where “\( P \)” is the hospital’s disproportionate patient percentage (as defined in clause (vi)).

(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula:

\[ \frac{P_{\text{min}}}{} \times 2.5 \]  

where “\( P \)” is the hospital’s disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(ii) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(iii) during each of fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent;

(iv) during fiscal year 2002, such additional payment amount shall be reduced by 4 percent; and

(v) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (i) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital’s target amount for the cost reporting period (as defined in subsection (b)(3)(D) of this section) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006, 50 percent of the amount by which the hospital’s target amount for the cost reporting period (as defined in subsection (b)(3)(D) of this section) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (g)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term “medicare-dependent, small rural hospital” means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A of this subchapter.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking into account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.
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(J)(i) The Secretary shall treat the term "transfer case" (as defined in subparagraph (I)(iii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term "qualified discharge" means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary); or

(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) of this section for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B) of this section.

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

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) of this section, and

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—
Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I), (C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(ii) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in each urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in the rural area of a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in each rural area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such rural area).

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county’s wage index to a level below the wage index for rural areas in the State in which the hospital is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area’s wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as if it were located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent) of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent) of the discharge-weighted average of—

(I) the national adjusted DRG prospective payment rate (determined under subparagraph (3)(D)) for hospitals located in a large urban area,

(II) such rate for hospitals located in other urban areas, and

(III) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area
wage levels. As used in this section, the term “subsection (d) Puerto Rico hospital” means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A) of this section) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B) of this section) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(i) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (i) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B) of this section, and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4) of this section, and adjusted to reflect the most recent case-mix data available.

(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph
in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(D).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(i)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after December 19, 1988.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital’s geographic classification for purposes of determining for a fiscal year—

(I) the hospital’s average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital’s geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpoenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to subchapter II of this chapter.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS–18 of the General Schedule under section 5332 of title 5 for each day (including travel time) during which such member is
engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, while away from their homes or regular places of business in the performance of services for the Board.

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term “applicable discharge” means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who is entitled to benefits under part A of this subchapter or any individual who is enrolled with a Medicare+ Choice organization under part C of this subchapter.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (b)(3)(D)(I) of this section) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(e) PROPORTIONAL ADJUSTMENTS IN APPLICABLE PERCENTAGE INCREASES

(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B) of this section) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) and (d)(5) of this section for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title), are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year;


(3) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary’s initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services as discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change
factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d) of this section, and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this subchapter under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary’s proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary’s final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission’s recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary’s recommendations under paragraph (4) differ from the Commission’s recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary’s grounds for not following the Commission’s recommendations.

(f) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d) of this section.

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this subchapter.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this subchapter).

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of subchapter XI of this chapter, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A of this subchapter with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (e) through (g) of section 1320a–7 of this title shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1320a–7(b)(13) of this title.

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) of this section and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1395x(v) of this title). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on August 10, 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) reevaluate which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.306(c) of that title), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;
(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) of this section as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this subchapter, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after April 20, 1983, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the “applicable percentage” is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987;
(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988;
(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and
(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this subchapter with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this subchapter by 15 percent.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) of this section or a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this subchapter with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) of this section or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this subchapter by 15 percent.

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital’s base period

The Secretary shall determine, for the hospital’s cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception

The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital’s reporting period, described in subparagraph (A), began on or

7So in original. Probably should be followed by a closing parenthesis.
(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) In general

Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) Freeze in update for fiscal years 1994 and 1995

For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) Floor in fiscal year 2001 at 70 percent of locality adjusted national average per resident amount

The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) Adjustment in rate of increase for hospitals with FTE approved amount above 140 percent of locality adjusted national average per resident amount

(I) Freeze for fiscal years 2001 and 2002

For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subparagraph (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 percent decrease in update for fiscal years 2003, 2004, and 2005

For a cost reporting period beginning during fiscal year 2003, fiscal year 2004, or fiscal year 2005, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) No adjustment below 140 percent

In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) Determination of locality adjusted national average per resident amount

The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) Determining hospital single per resident amount

The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) Standardizing per resident amounts

The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1395w–4(e) of this title for 1999 for the fee schedule area in which the hospital is located.

(iii) Computing of weighted average

The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).
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(3) Hospital payment amount per resident reporting period beginning on or after July 1, 1985, is equal to the product of—

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital’s medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term “aggregate approved amount” means, for a hospital cost reporting period, the product of—

(i) the hospital’s approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital’s approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) of this section for residents included in the hospital’s count of full-time equivalent residents.

(C) Medicare patient load

As used in subparagraph (A), the term “medicare patient load” means, with respect to a hospital’s cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(D) Payment for managed care enrollees

(i) In general

For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare+Choice organization under part C of this subchapter. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) Applicable percentage

For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000, and

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) Proportional reduction for nursing and allied health education

The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000)

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such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (i) of this section for portions of cost reporting periods occurring in that year.

(iv) Special rule for hospitals under reimbursement system

The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(F) Limitation on number of residents in allopathic and osteopathic medicine

(i) In general

Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital’s most recent cost reporting period ending on or before December 31, 1996.

(ii) Counting primary care residents on certain approved leaves of absence in base year FTE count

(I) In general

In determining the number of such full-time equivalent residents for a hospital’s most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) Limitation to 3 FTE residents for any hospital

The total number of individuals counted under subclause (I) for a hospital may
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not exceed 3 full-time equivalent residents.

(G) Counting interns and residents for FY 1998 and subsequent years

(i) In general

For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital’s graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) Adjustment for short periods

If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) Transition rule for 1998

In the case of a hospital’s first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) Special rules for application of subparagraphs (F) and (G)

(i) New facilities

The Secretary shall, consistent with the principles of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(ii) Aggregation

The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) Data collection

The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) Nonrural hospitals operating training programs in rural areas

In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(5) Definitions and special rules

As used in this subsection:

(A) Approved medical residency training program

The term “approved medical residency training program” means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) Consumer price index

The term “consumer price index” refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) Direct graduate medical education costs

The term “direct graduate medical education costs” means direct costs of approved educational activities for approved medical residency training programs.

(D) Foreign medical graduate

The term “foreign medical graduate” means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS examination

The term “FMGEMS examination” means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term “initial residency period” means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a pre-
ventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) Period of board eligibility

(i) General rule

Subject to clauses (ii), (iii), (iv), and (v), the term “period of board eligibility” means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) Application of 1985–1986 directory

Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) Changes in period of board eligibility

On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) Special rule for certain primary care combined residency programs

(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(v) Child neurology training programs

In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) Primary care resident

The term “primary care resident” means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) Resident

The term “resident” includes an intern or other participant in an approved medical residency training program.

(j) Adjustments for certain family practice residency programs

(i) In general

In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this subchapter or a State plan under subchapter XIX of this chapter) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary’s estimate of the amount that would have been recognized as reasonable under this subchapter if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this subchapter.

(ii) Additional requirements

A hospital’s approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (1)(I)) does not exceed $10,000.

(6) Incentive payment under plans for voluntary reduction in number of residents

(A) In general

In the case of a voluntary residency reduction plan for which an application is ap-
proved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) of this section for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this subchapter in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) Approval of plan applications

The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and not later than November 1, 1999;10

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) Qualifying entity

For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) Residency reduction requirements

(i) Individual hospital applicants

In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent

(ii) Joint applicants

In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) Consortia

In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) Manner of reduction

The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) Entities providing assurance of increase in primary care residents

An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

10So in original. The comma probably should be a semicolon.
(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) “Base number of residents” defined

For purposes of this paragraph, the term “base number of residents” means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) Applicable hold harmless percentage

For purposes of subparagraph (A), the “applicable hold harmless percentage” for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,
(ii) third such year, 75 percent,
(iii) fourth such year, 50 percent, and
(iv) fifth such year, 25 percent.

(F) Penalty for noncompliance

(i) In general

No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) Increase in number of residents in subsequent years

If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) Treatment of rotating residents

In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(i) Avoiding duplicative payments to hospitals participating in rural demonstration programs

The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 11205(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) Prospective payment for inpatient rehabilitation services

(1) Payment during transition period

(A) In general

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a “rehabilitation facility”), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this subchapter with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) Fully implemented system

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA and prospective payment percentages specified

For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the “TEFRA percentage” is 66 2/3 percent and the “prospective payment percentage” is 33 1/3 percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the “TEFRA percentage” is 33 1/3 percent and the “prospective payment percentage” is 66 2/3 percent.

(D) Payment unit

For purposes of this subsection, the term “payment unit” means a discharge.
(E) Construction relating to transfer authority

Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(2) Patient case mix groups

(A) Establishment

The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a “case mix group”), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) Weighting factors

For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

(C) Adjustments for case mix

(i) In general

The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this subchapter, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) Adjustment

Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) Data collection

The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) Payment rate

(A) In general

The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this subchapter. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this subchapter for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) of this section (for cost reporting periods beginning during the fiscal year covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) Budget neutral rates

The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary’s estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6)) shall be equal to 98 percent of the amount of payments that would have been made under this subchapter during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) Increase factor

For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall es-
establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii) of this section.

(4) Outlier and special payments

(A) Outliers

(i) In general

The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) Payment based on marginal cost of care

The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) Total payments

The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) Adjustment

The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) Publication

The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the methodology and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) Area wage adjustment

The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities’ costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) Payment to nonhospital providers

(1) In general

For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h) of this section. Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this subchapter.

(2) Qualified nonhospital providers

For purposes of this subsection, the term “qualified nonhospital providers” means—

(A) a Federally qualified health center, as defined in section 1395x(aa)(4) of this title;

(B) a rural health clinic, as defined in section 1395x(aa)(2) of this title;

(C) Medicare+Choice organizations; and

(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(i) Payment for nursing and allied health education for managed care enrollees

(1) In general

For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1395ww of this title.

(2) Payment amount

The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

\footnote{So in original. Probably should not be capitalized.}
(A) Determination of managed care enrollee payment ratio for graduate medical education payments

The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) of this section to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3) of this section.

(B) Application to fee-for-service nursing and allied health education payments

Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under paragraph (a)(1) of this section for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year except that in no case shall such total amount exceed $60,000,000 in any year.

(C) Application to hospital

The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods.


References in Text

Parts A and B of this subchapter, referred to in text, are classified to sections 1385c et seq. and 1386 et seq., respectively, of this title.

The Internal Revenue Code of 1986, referred to in subsec. (b)(6), is classified generally to Title 26, Internal Revenue Code.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (c)(4)(B), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

Section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(2)(C)(i), is section 9104(a) of Pub. L. 99–272, which amended subsec. (d)(5)(B) of this section.


Section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (d)(2)(C)(iv), is section 111 of Pub. L. 106–113, which amended this section and enacted provisions set out as a note under this section.

Section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (d)(2)(C)(iv), is section 6003(c) of Pub. L. 100–203, which amended this section and enacted provisions set out below.

Section 6002(b) of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(2)(C)(iv), is section 6002(b) of Pub. L. 101–508, which amended this section and enacted provisions set out below.

Section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(3)(C)(ii), is section 9104 of Pub. L. 100–360, which amended subsec. (d)(2)(C)(i), (3)(C), (D)(i)(1), (ii)(I), and (B)(i) of this section.


Part C of this chapter, referred to in subsecs. (d)(11)(B) and (h)(3)(D)(i), is classified to section 1320c–2 et seq. of this title.

Section 1904 of the Omnibus Budget Reconciliation Act of 1988, referred to in subsec. (e)(1)(C)(ii), is section 1904 of Pub. L. 99–514, which enacted subsec. (d)(9) and (e)(1)(C) of this section and amended subsec. (d)(5)(C)(i)(I) of this section.

Part B of subchapter XI of this chapter, referred to in subsec. (f)(2), is classified to section 1320c et seq. of this title.


Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (i), is section 4005(e) of Pub. L. 100–203, which is set out below.

AMENDMENTS


Subsec. (b)(2)(A). Pub. L. 106–113, § 1000(a)(6) [title I, § 122(1)], substituted “Except as provided in subparagraph (E), in addition to” for “In addition to”.


Subsec. (b)(8)(B). Pub. L. 106–113, § 1000(a)(6) [title IV, § 404(a)(2)], insertedheading and substitutedin “a subsequent clause” for “clause (ii)”, and the approved FTE resident amount determined for “the amount determined”.

Subsec. (b)(2)(D)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 331(a)(1), (b)(1)], inserted heading and substitutedin “a subsequent clause” for “clause (ii)” and “the approved amounts determined for “the amount determined”.


Subsec. (b)(2)(E). Pub. L. 106–113, § 1000(a)(6) [title III, § 331(a)(3), (4)], added subpar. (E) and redesignated former subpar. (E) as (F).


Subsec. (b)(4)(F). Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(a)(1)], inserted "or 130 percent of such number in the case of a hospital located in a rural area" after "may not exceed the number"


Subsec. (b)(5)(F). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(1)], substituted "subject to subparagraph (G)(v)", the initial residency period" for "the initial residency period" in concluding provisions.


Subsec. (j)(1)(D). Pub. L. 106–113, § 1000(a)(6) [title I, § 1252(a)(1)], struck out "day of inpatient hospital services, or other unit of payment defined by the Secretary" before period at end.


Subsec. (j)(2)(A). Pub. L. 106–113, § 1000(a)(6) [title I, § 1252(a)(2)], amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and"

Subsec. (l), added subsec. (l).

1997—Subsec. (l). Pub. L. 105–33, § 4422(b)(1), inserted "and other than a rehabilitation facility described in subsection (j)(1)(A) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to,"

Subsec. (b)(4)(A)(i). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"

Subsec. (b)(4)(A)(ii). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"


Subsec. (b)(4)(A)(iv). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"

Subsec. (b)(4)(A)(v). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"

Subsec. (b)(4)(A)(vi). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"

Subsec. (b)(4)(A)(vii). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to" and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"

Subsec. (l), added subsec. (l).

1997—Subsec. (l). Pub. L. 105–33, § 4422(b)(1), inserted "and other than a rehabilitation facility described in subsection (j)(1)(A) of this section, may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception and adjustment to;"


Subsec. (b)(4)(C)(i). Pub. L. 105–33, § 4421(a)(2), inserted at end "except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(A)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997,"

Subsec. (d)(5)(A)(ii). Pub. L. 105–33, § 4406(c), substituted "exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)" for "exceed the applicable DRG prospective payment rate".

Subsec. (d)(5)(B)(iv). Pub. L. 105–33, § 4406(a), inserted ", for cases qualifying for additional payment under subparagraph (A)(ii)," before "the amount paid to the hospital",

Subsec. (d)(5)(B)(ii). Pub. L. 105–33, § 4621(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, 1988, is equal to 1.89 \times (1 + \frac{r}{10})\text{,}" where \(r\) is the ratio of the hospital's full-time equivalent interns and residents to beds and \(r\) equals 0.595.

Subsec. (d)(5)(B)(iv). Pub. L. 105–33, § 4621(b)(2), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: "In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents) as part of the calculation of the full-time-equivalent number of interns and residents,"

the scope of the Commission's responsibilities" for "hospital reimbursement, hospital financial management".

Subsec. (b)(5)(E). Pub. L. 103–432, §153(a), inserted "or any successor examination" after "Medical Sciences.

1993—Subsec. (b)(3)(B)(ix)(X). Pub. L. 103–66, §13501(a)(1)(A), substituted "percentage increase minus 2.5 percentage points for hospitals" and struck out "and subsequent fiscal year" after "1996", inserted "minus 2.0 percentage points" after "percentage increase for hospitals" and struck out "and each subsequent fiscal year" after "1996", inserted "minus 2.0 percentage points" after "percentage increase plus 1.5 percentage points".

Subsec. (b)(3)(B)(x). Pub. L. 103–66, §13501(a)(1)(B), substituted "percentage increase minus 2.5 percentage points for hospitals" for "percentage increase for hospitals" and struck out "and" at end.


Subsec. (b)(3)(B)(ii)(III) to (VI). Pub. L. 103–66, §13502(a)(1), struck out "and" at end of subcl. (III), in subcl. (IV), substituted "a subsequent fiscal year ending on or before September 30, 1993," for "subsequent fiscal years" and a comma for the period at end, and added subcls. (V) and (VI).


Subsec. (b)(3)(C)(ii). Pub. L. 103–66, §13501(a)(2)(B)(iii), substituted "period beginning before fiscal year 1994, the target" for "period, the target", "subparagraph (B)(iv)" for "subparagraph (B)(ii)" and a comma for period at end.


Subsec. (b)(4)(A). Pub. L. 103–66, §13502(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(1)(A)(iii). Pub. L. 103–66, §13501(f), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "beginning on or after April 1, 1988, and ending on September 30, 1993, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph."

Subsec. (d)(5)(A)(i). Pub. L. 103–66, §13501(c)(1), substituted "For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary" for "The Secretary".

Subsec. (d)(5)(A)(ii). Pub. L. 103–66, §13501(c)(2), substituted "or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the applicable DRG prospective payment rate plus a fixed dollar amount determined by the Secretary."

Subsec. (d)(5)(A)(iii). Pub. L. 103–66, §13501(c)(3), substituted "shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (vi)) approximate" for "shall approximate."


Subsec. (d)(5)(B)(iv). Pub. L. 103–66, §13501(c)(4), added "or providing services at any entity receiving a grant under section 254c of this title that is under the owner-

ship or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents)" after "the hospital".

Subsec. (d)(5)(G)(i). Pub. L. 103–66, §13501(e)(1)(A), which directed amendment of subsec. (d)(5)(G) in clause (i) in the matter preceding subclause (I), by striking "and each subsequent fiscal year ending on or before March 31, 1994." and all that follows and inserting "before October 1, 1994, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the hospital determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).", was executed by substituting the new language for "ending on or before March 31, 1994, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—"

"(i) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D) of this section, or"

"(ii) the amount determined under paragraph (1)(A)(iii), whichever results in the greater payment to the hospital," to reflect the probable intent of Congress.


Subsec. (h)(5)(H). (I). Pub. L. 103–66, §13563(a)(1), inserted "or a preventive medicine residency or fellowship program" after "fellowship program".

Subsec. (h)(5)(I). Pub. L. 103–66, §13563(b)(1)(A)(i), inserted "or" and redesignated former cls. (ii) and (iii) as (ii) and (iv), respectively.


1990—Subsec. (a)(4). Pub. L. 101–508, §4003(a), struck out period at end of first sentence and inserted ", and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary)."

Subsec. (b)(1)(B)(ii). Pub. L. 101–508, §4005(a)(1), added (D) and struck out former cl. (D) which read as follows: "in the case of cost reporting periods beginning on or after October 1, 1992, and before October 1, 1994, 25 percent of the amount by which the operating costs exceeds the target amount.


Subsec. (b)(3)(B)(i)(V). Pub. L. 101–508, §4002(a)(1)(A), substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area" for "in all areas".


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Subsec. (d)(3)(A)(ii) to (v). Pub. L. 101–508, § 4002(c)(2)(B)(ii)(II), (III), added cls. (iii) and (iv) and redesignated former cl. (iii) as (v).

Subsec. (d)(3)(B). Pub. L. 101–508, § 4002(c)(2)(B)(iii), substituted ‘‘by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments))’’ for ‘‘for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area.’’

Subsec. (d)(3)(C)(i). Pub. L. 101–508, § 4002(b)(3)(B)(v), substituted ‘‘occurring on or after October 1, 1986, through the end of cl. (I) for ‘‘occurring—’’ and subcls. (I) and (II) which read as follows:

‘‘(I) on or after October 1, 1986, and before October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

‘‘(II) on or after October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987.’’


Subsec. (d)(4)(D). Pub. L. 101–508, § 4002(c)(2)(B)(A), struck out subpar. (D) which read as follows: ‘‘The Commission (established under subsection (e)(2) of this section) shall consult with and make recommendations to the Secretary with respect to the need for adjustments under subparagraph (C), based upon its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities. The Commission shall report to the Congress with respect to its evaluation of any adjustments made by the Secretary under subparagraph (C).’’


‘‘(I) on or after May 1, 1986, and before October 1, 1995, is equal to 1.43×[(1+r)p−1], or

‘‘(II) on or after October 1, 1995, is equal to 1.43×(1+r)p−1, where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds.’’

Subsec. (d)(5)(D)(i). Pub. L. 101–508, § 4008(m)(2)(A), substituted ‘‘For purposes of this subchapter, the term ‘for the term’ at beginning.’’


Subsec. (d)(5)(F)(vii)(II). Pub. L. 101–508, § 4002(b)(1)(A), substituted "hospitals—" and subst. (a) to (c) for "hospitals, (P – 15)(.6)+2.5, ".

Subsec. (d)(8)(C)(i). Pub. L. 101–508, § 4002(b)(1)(A)(i), substituted "area, or by treating hospitals located in one urban area as being located in another urban area—" for "area—"

Subsec. (d)(8)(C)(ii). Pub. L. 101–508, § 4002(b)(1)(A)(ii), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) to the hospitals so treated (as if each affected rural county were a separate urban area)."

Subsec. (d)(8)(C)(iii). Pub. L. 101–508, § 4002(b)(1)(A)(iii), (iv), redesignated cl. (ii) and (iv) as (i) and (ii), respectively, and struck out former cl. (i) which read as follows: "If the application of subparagraph (B) or a decision of Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area—"

"(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or 

"(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area)."

Subsec. (d)(9)(D). Pub. L. 101–508, § 4002(c)(2)(B)(vi), struck out "for hospitals located in an urban area" after "determined under paragraph (3)" and struck out at end "The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate payments to rural hospitals not affected by subparagraph (B) or (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) are not changed as a result of the application of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),"

Subsec. (d)(10)(A). Pub. L. 101–508, § 4002(b)(2)(B)(i), substituted "Geographical" for "Geographical for", and substituted "representative for "representatives" and struck out "1 member shall be a member of the Prospective Payment Assessment Commission, and at least after "At least"

Subsec. (d)(10)(B)(i). Pub. L. 101–508, § 4002(b)(2)(B)(i), substituted "representative for "representatives" and struck out "1 member shall be a member of the Prospective Payment Assessment Commission, and at least after "At least"


Subsec. (d)(10)(C)(i)(II). Pub. L. 101–508, § 4002(b)(2)(B)(iv), substituted "Appeal decisions of the Board shall be subject to the provisions of section 557b of title 5" for "A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board" and substituted "after the date on which" for "after".

Subsec. (e)(2)(A). Pub. L. 101–508, § 4002(g)(2)(B), substituted "The Commission" for "in addition to carrying out its functions under subsection (d)(4)(D) of this section, the Commission"

Subsec. (e)(3)(A). Pub. L. 101–508, § 4002(g)(2)(C), substituted "Congress" for "the Secretary and inserted before period at end ", together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States".

Subsec. (e)(4). Pub. L. 101–508, § 4002(g)(2)(D), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (e)(5). Pub. L. 101–508, § 4002(g)(2)(E), substituted "recommendations" for "recommendation" in subpars. (A) and (B) and inserted at end "To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations"

Subsec. (e)(6)(G). Pub. L. 101–508, § 4002(g)(2)(F), redesignated cls. (ii) and (iii) as (i) and (ii), respectively, and struck out former cl. (i) which read as follows: "The Office shall report annually to the Congress on the functioning and progress of the Commission and on the status of the assessment of medical procedures and services by the Commission."

Subsec. (g)(1)(A). Pub. L. 101–508, § 4001(b), inserted at end "Aggregate payments made under subsection (d) of this section and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1355v(v) of this title)."


Subsec. (g)(3)(B). Pub. L. 101–508, § 4001(c), substituted "recommendations" for "recommendation" in subpars. (d)(5)(D)(ii) of this section or a rural primary care hospital (as defined in section 1395x(mm)(1) of this title) for "subsection (d)(5)(D)(ii) of this section"

1989—Subsec. (a)(4). Pub. L. 101–239, § 601(a), struck out "or", after "equity capital," and substituted "October 1, 1987," or costs with respect to administering blood clotting factors to individuals with hemophilia for "October 1, 1987"

Subsec. (b)(3)(A). Pub. L. 101–239, § 6001(b)(1)(A), substituted "(C), (D), and (E)" for "(C) and (D)" in introductory provisions.

Pub. L. 101–239, § 6003(f)(2)(i), substituted "(C), (D), and (E)" for "(C), (D), and (E)" in introductory provisions.

Pub. L. 101–239, § 6003(f)(2)(ii), substituted "subparagraphs (C) and (D)" for "subparagraph (C)" in introductory provisions.

Pub. L. 101–239, § 6003(e)(1)(B)(i), (VI), Pub. L. 101–239, § 6003(e)(1)(B)(i), substituted "(C), (D), and (E)" for "(C) and (D)" in introductory provisions.


Subsec. (b)(3)(B)(ii). Pub. L. 101–239, § 6004(b)(1)(B), substituted "For purposes of subparagraphs (A) and (E)" for "For purposes of subparagraph (A)" in introductory provisions.


Subsec. (b)(4)(A). Pub. L. 101–239, § 601(a), substituted "deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and nec-
essay cost of inpatient services and" for “deems appropriate.”

Subsec. (c)(4). Pub. L. 101–239, § 6022, substituted “the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available” for “the aggregate payment or payments per inpatient admission or discharge during the three cost reporting periods beginning on or after October 1, 1983, after which such test, at the option of the Secretary, shall no longer apply, and such State systems shall be treated in the same manner as under other waivers” in second sentence.


Subsec. (d)(3)(E). Pub. L. 101–239, § 6003(b)(6), substituted “October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)” for “October 1, 1990 (and at least every 36 months thereafter)” and inserted at end “Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.”

Subsec. (d)(4)(C). Pub. L. 101–239, § 6003(b), designated existing provisions as cl. (i) and added cls. (ii) to (iv).

Subsec. (d)(5)(C). Pub. L. 101–239, § 6003(e)(1)A)(1), (11), redesignated former cl. (iii)(II) as cl. (ii) and substituted “clause (i)” for “subclause (I)” in three places, and redesignated former cls. (ii), (iii), and (iv) as subpars. (D), (E), and (F), respectively.

Subsec. (d)(5)(D). Pub. L. 101–239, § 6003(e)(1)(A)(iv), amended former subpar. (C)(i) generally, redesignating it as subpar. (D) and redesignating cls. (i) to (iv) relating to payments to sole community hospitals for cost reporting periods beginning on or after Apr. 1, 1990, for former single paragraph relating to payments to such hospitals for cost reporting periods beginning on or after Oct. 1, 1984.


Subsec. (d)(5)(F)(v). Pub. L. 101–239, § 6003(c)(1)(A), substituted “the applicable formula described in clause (vii)” for “the following formula: (P −15)(3.5)+2.5, where ‘P’ is the hospital’s disproportionate patient percentage as defined in clause (vii)”.

Subsec. (d)(5)(F)(vii). Pub. L. 101–239, § 6003(c)(2)(A)(ii), inserted “in subclause (IV) or (V) or” after “described”.

Subsec. (d)(5)(F)(v)(V) to (VI). Pub. L. 101–239, § 6003(c)(2)(A)(i), (iii), (IV), added subcl. (V) to (VI).

Subsec. (d)(5)(F)(v)(V). Pub. L. 101–239, § 6003(c)(2)(B), added subcl. (II), redesignated former subcls. (III) and (IV) as (III) and (IV), respectively, and substituted “area and is not described in subclause (II)” for “‘area’ in subcl. (IV).


Subsec. (d)(5)(I). Pub. L. 101–239, § 6004(a)(2), struck out “(including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)” after “deems appropriate”.


Subsec. (d)(5)(J)(v). Pub. L. 101–239, § 6003(h)(3), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows:

“(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), [sic] by treating hospitals located in a rural county or counties as being located in an urban area, reduces the wage index for that urban area (as applied under this subsection), the Secretary shall calculate and apply such wage index to all hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), [sic] by treating the hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

“(iii) Clause (i) shall only apply to discharges occurring on or after October 1, 1989, and before October 1, 1991.”

Subsec. (d)(8)(C)(i). Pub. L. 101–239, § 6003(h)(2), substituted “subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),” for “subparagraph (B)” in two places.


Subsec. (d)(8)(D). Pub. L. 101–239, § 6003(h)(2)(B), substituted “(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)” for “(B) and (C)” in three places.


Subsec. (d)(9)(D)(iv). Pub. L. 101–239, § 6003(e)(2)D)(i), redesignated former cl. (ii) as (iv), substituted “Subparagraph (H)” for “Subparagraph (C)(i)”, and struck out former cl. (iv) which read as follows: “Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).”


Subsec. (g)(3)(A)(iv). Pub. L. 101–234, § 301(b)(3), (c)(3), amended cl. (iv) identically, substituting “(as the case may be)” for “(as the case may be)”.


Pub. L. 100–360, § 411(b)(1)A)(ii), substituted “for hospitals” for “for hospitals” before “located in other urban areas”.

Pub. L. 100–360, § 411(b)(1)A)(i), substituted “for hospitals” for “for hospitals” before “located in other urban areas”.

Pub. L. 100–360, § 411(b)(1)A)(A), substituted “for hospitals” for “for hospitals” before “located in other urban areas”.

Pub. L. 100–360, § 411(b)(1)G), substituted “for hospitals” for “for hospitals” before “located in other urban areas”.

Pub. L. 100–360, § 411(b)(1)C), inserted “increase” after “market basket percentage”.
same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for “if greater”.


Subsec. (b)(3)(B)(i). Pub. L. 100–203, §4002(e)(1), struck out “subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of” after “For purposes of”.

Subsec. (b)(3)(B)(ii). Pub. L. 100–203, §4002(a)(1), (2), redesignated former cl. (ii) as (iii), added cl. (ii), redesignated former cl. (ii) as (i), and inserted “For purposes of this subparagraph for purposes of subparagraph (A)” for “For purposes of clause (i)”.

Subsec. (d)(1)(A)(i). Pub. L. 100–203, §4002(d)(2), inserted before period at end “or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.

Subsec. (d)(8)(B). Pub. L. 100–360, §411(b)(4)(A)(ii), substituted “For purposes of this subsection, the Secretary” for “The Secretary”.


Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100–360, §411(b)(5)(A), inserted “For purposes of clause (i)”.

Subsec. (d)(3)(A)(iii). Pub. L. 100–203, §4002(a)(1), (2), inserted “For purposes of” before period at end “or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.

Subsec. (d)(2)(D). Pub. L. 100–360, §4002(f)(1)(A), in subsection “For purposes of this subparagraph for purposes of subparagraph (A)” for “For purposes of clause (i)”.

Subsec. (d)(2)(D). Pub. L. 100–360, §4002(d)(2), inserted before period at end “or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.


Subsec. (b)(3)(B)(i). Pub. L. 100–203, §4002(e)(1), struck out “subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of” after “For purposes of”.

Subsec. (b)(3)(B)(ii). Pub. L. 100–203, §4002(a)(1), (2), redesignated former cl. (ii) as (iii), added cl. (ii), redesignated former cl. (ii) as (i), and inserted “For purposes of this subparagraph for purposes of subparagraph (A)” for “For purposes of clause (i)”.

Subsec. (d)(1)(A)(iii). Pub. L. 100–203, §4002(d)(2), inserted before period at end “or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.


Subsec. (g)(3)(A)(iv). Pub. L. 100–360, §411(b)(5)(A), inserted “For purposes of this subparagraph for purposes of subparagraph (A)” for “For purposes of clause (i)”.

Subsec. (d)(3)(A)(iv). Pub. L. 100–203, §4002(d)(2), inserted before period at end “or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.


sidered located in urban area or large urban area, respectively, if it is paid under this subsection at rate for hospitals located in such area.

Subsec. (d)(4). Pub. L. 100–203, § 4009(d)(1), as added by Pub. L. 100–360, § 411(b)(6)(B), substituted “a large urban area,” for “an urban area, and” in subcl. (I), added subcl. (II), and redesignated former subcl. (II) as (III).

Subsec. (d)(9)(B). Pub. L. 100–203, § 4009(j)(3)(A), as added by Pub. L. 100–360, § 411(b)(3), inserted at end “The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.”


Subsec. (e)(4). Pub. L. 100–203, § 4009(j)(1)(C), substituted “for each fiscal year (beginning with fiscal year 1988)” for “for fiscal year 1988”, struck out “and” shall determine for each subsequent fiscal year the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) of this section) for discharges in that fiscal year, and after “in that fiscal year” in a large urban area, and amended last sentence generally. Prior to amendment, last sentence read as follows: “The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be determined from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.”


Subsec. (e)(6)(B). Pub. L. 100–203, § 4009(j)(1), as amended by Pub. L. 100–360, § 411(b)(8)(B), substituted “include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives” for “provide expertise and experience in the provision and financing of health care”, and struck out last sentence which required Director to seek nominations from wide range of groups, including specified types of national organizations.

Subsec. (e)(6)(D). Pub. L. 100–203, § 4009(j)(6)(B), inserted at end “For purposes of payment of any payments to the Secretary...” for “members of the Commission” and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.”


Subsec. (f)(3). Pub. L. 100–93 amended par. (3) generally. Prior to amendment, par. (3) read as follows: “The provisions of paragraphs (2), (3), and (4) of section 1395y(d) of this title shall apply to determinations made under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1395y(d)(1) of this title.”

Subsec. (g)(1). Pub. L. 100–203, § 4006(b)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: “If the Congress does not enact legislation,
after April 20, 1983, and before October 1, 1987, respecting the payment under this subchapter for capital-related costs for inpatient hospital services, no payment may be made under this subchapter for capital-related costs of capital expenditures (as defined in section 1320a–1(c) of this title and except as provided in section 1320a–1(j) of this title) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1987, unless the State has an agreement with the Secretary under section 1320a–1(b) of this title and under the agreement the Secretary has recommended application of the capital expenditures.

Subsec. (g)(3)(A) to (iv). Pub. L. 100–203, § 4006(a), as amended by Pub. L. 100–360, § 411(b)(5)(B), substituted “on or after October 1, 1987, and before October 1, 1988,” for “on or after October 1, 1987,” and added cl. (iv), and struck out former cl. (iii) which read as follows: “10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.”

Subsec. (g)(3)(C). Pub. L. 100–203, § 4006(b)(2)(B), struck out subpar. (C) which read as follows: “If the Secretary provides, under subsection (a)(4) of this section, for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

(i) notwithstanding any other provision of this subchapter, for the continuation of payment under the reasonable cost methodology described in section 1395x(v)(1) of this title with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

(ii) in the design of such payment system that the aggregate payment amount under this subchapter for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this subchapter that would have been made (taking into account the provisions of subparagraphs (A) and (B)), during that fiscal year but for the inclusion of such costs by the Secretary.”

Subsec. (h)(4)(C). Pub. L. 100–203, § 4009(j)(5), substituted “subparagraph (D)” for “subparagraph (E)”.

1986—Subsec. (a)(4). Pub. L. 99–509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100–203, § 4009(j)(6)(A), struck out subpar. (C) which read as follows: “(ii) in the design of such payment system that the aggregate payment amount under this subchapter for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this subchapter that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary.”

Subsec. (b)(3)(B). Pub. L. 99–272, § 9101(b), amended subsec. (b) generally. Prior to amendment, subpar. (B) read as follows: “For purposes of subparagraph (A) and subsection (d) of this section and except as provided in subsection (e) of this section, the applicable percentage increase for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of such mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year. In determining a percentage change under subsection (e)(4) of this section with respect to discharges occurring in any cost reporting period or fiscal year after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.”

Subsec. (b)(3)(B)(ii). Pub. L. 99–509, § 9302(a)(1), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: “for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (a)(4) of this section, but not to exceed the market basket percentage increase (as defined in clause (i)), and”


Subsec. (d)(1)(C). Pub. L. 99–272, § 9102(b), struck out “or discharges occurring” after “periods beginning” in introductory provision, and “and” after “percent,” in cl. (ii), added cl. (iii), redesignated former cl. (iii) as (iv), and in cl. (iv) substituted “on or after October 1, 1986, and before October 1, 1987” for “on or after October 1, 1985, and before October 1, 1986”.


Pub. L. 99–272, § 9104(b)(1), inserted “(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 914(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)” after “medical education costs”.


Pub. L. 99–509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100–203, § 4009(j)(6)(A), struck out Pub. L. 99–514, § 1895(b)(1)(A), which had directed insertion of “If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.”


Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(B), which had directed insertion of “If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.”

Pub. L. 99–272, § 9101(c)(1), substituted “for each of fiscal years 1985 and 1986” for “for fiscal year 1985”.

Subsec. (d)(3)(B). Pub. L. 99–509, § 9302(b)(1), inserted “for hospitals located in an urban area and for hospitals located in a rural area” after “paragraph (A),” and inserted before the period “for hospitals located in such respective area.”


Pub. L. 99–509, § 9307(c)(1)(A), struck out Pub. L. 99–514, § 1895(b)(1)(C), which had directed a general amendment of cl. (ii) to read as follows: “The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between—

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Secretary shall use an educational adjustment factor equal to 1.159 for '1989' for '1989'.

Subsec. (d)(5)(F)(i). Pub. L. 99–599, § 9306(b)(1), inserted "or is described in the second sentence of subsection (d)(5)(F)(ii)" after "1989 or more beds".


Subsec. (d)(5)(F)(v). Pub. L. 99–599, § 9306(a), inserted at end "A hospital located in a rural area and with 500 or more beds also serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (v)) for that period which equals or exceeds a percentage specified by the Secretary. 


Subsec. (e)(3). Pub. L. 99–599, § 9302(e)(3), designated existing provisions as subpar. (A) and added subpar. (B). 


Subsec. (g)(2). Pub. L. 99–272, § 9107(a)(1), designated existing provision as subpar. (A), inserted the applicable percentage (described in subparagraph (B)) of", and added subpar. (B). 


Subsec. (i). Pub. L. 99–599, § 9302(a)(2)(A), redesignated paragraph "as used in this paragraph, the" for "as used in this paragraph, the".

Subsec. (a)(4). Pub. L. 98–369, § 2312(b), temporarily inserted “,” costs of anesthesia services provided by a certificated registered nurse anesthetist” after “approved establishment activities”. See Effective and Termination Dates of 1984 Amendments note below.


Subsec. (b)(3)(B). Pub. L. 8–369, § 2310(a), substituted “one-quarter of one percentage point” for “1 percentage point” and inserted provision that in determining the percentage change under subsec. (e) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after Oct. 1, 1985, and before Oct. 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.

Subsec. (c)(4)(A). Pub. L. 98–369, § 2313(a), substituted “(D), and (E)” for “and (D)”


Pub. L. 98–369, § 2311(b), inserted provision for determining the region a hospital located in a Metropolitan Statistical Area would be deemed to be located.


Subsec. (d)(5)(B). Pub. L. 98–369, § 2307(b)(1), inserted provision that in determining such adjustment the Secretary not distinguish between those interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of such hospital.

Subsec. (d)(5)(C)(i). Pub. L. 98–367 substituted “August 17, 1984” for “30 days after July 17, 1984” before “for implementation by”. Pub. L. 98–369, § 2311(a), inserted provisions permitting a hospital classified as a rural hospital to appeal in 60 days after the date the appeal was submitted. Pub. L. 8–369, § 2339(b)(47), substituted “(B)” for “(D)”.


Subsec. (e)(2). Pub. L. 98–369, § 2313(a), inserted “‘without regard to the provisions of title 5 governing appointments in the competitive service’” after “‘appointed by the Director’”.

Subsec. (e)(5). Pub. L. 98–369, § 2315(c)(1), struck out for “public comment” after “have published” in provision preceding subpar. (A).

Subsec. (e)(5)(A). Pub. L. 98–369, § 2315(c)(2), inserted “for public comment” after “that fiscal year”.

Subsec. (e)(6)(C). Pub. L. 98–369, § 2313(b)(3), inserted provision that section 196a(1) of the Federal Advisory Committee Act not apply to any portion of a Commission meeting if the Commission, by majority vote, determines such portion of such meeting should be closed.

Subsec. (e)(6)(C)(i). Pub. L. 98–369, § 2313(b)(1), amended cl. (i) generally, substituting provision authorizing the Commission to employ and fix the compensation of the Executive Director, subject to the approval of the Director of the Office, and such other personnel, not to exceed 25, as necessary, without regard to the provisions of title 5 governing appointment in the competitive service, for provision authorizing the Commission to employ and fix the compensation of such personnel, not to exceed 25, as may be necessary to carry out its duties.


Subsec. (e)(6)(D). Pub. L. 98–369, § 2313(b)(4), inserted provision relating to payment of physician comparability allowances in the same manner as it applies to the Tennessee Valley Authority.


Subsec. (a)(4). Pub. L. 98–21, § 601(a)(2), inserted provision that term “operating costs of inpatient hospital services” does not include costs of approved educational activities, or, with respect to costs incurred in cost reporting periods beginning prior to Oct. 1, 1986, capital-related costs, as defined by the Secretary.

Pub. L. 97–448, § 309(b)(13), substituted “‘as such costs are determined’” for “‘and such costs are determined’”.

Subsec. (b)(1). Pub. L. 98–21, § 601(b)(1), (2), in provisions preceding subpar. (A), substituted “Notwithstanding section 1395b of this title but subject to the provisions of sections 1395e of this title” for “Notwithstanding sections 1395b of this title, but subject to the provisions of sections 1395e of this title” and inserted “‘other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section’”.

Pub. L. 98–21, § 601(b)(3), inserted “‘other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section’” in provisions following subpar. (B).


Subsec. (b)(3)(B). Pub. L. 98–21, § 601(b)(5)–(8), inserted “‘and subsection (d) of this section and except as provided in subsection (e) of this section’” after “subparagraph (A)’, inserted “‘or fiscal year’” after “‘cost reporting period’” each place it appears, inserted “‘before the beginning of the period or year’” after “‘estimated by the Secretary’”, and substituted “‘will exceed’” for “‘exceeds’”.

Subsec. (b)(6). Pub. L. 98–21, § 601(b)(9), added par. (6) and repealed a prior par. (6) which directed the Secretary to provide for an adjustment under this paragraph in the amount of payment otherwise provided a hospital under this subsection in the case of a hospital which, as of Aug. 15, 1982, was subject to FICA taxes and which was not subject to such taxes for part or all of a cost reporting period beginning on or after Oct. 1, 1982, that in making such adjustment for a cost reporting period the Secretary was to estimate the amount of the operating costs of inpatient hospital services that would have resulted if the hospital was subject to the FICA taxes during that period. After making such estimate the Secretary was to reduce the amount of such FICA taxes that would have been paid (not below zero) by the amount of costs which the hospital demonstrated to the satisfaction of the Secretary were incurred in the period for pensions, health, and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under subchapter H of this chapter and this subchapter, that if a hospital’s operating costs of inpatient hospital services estimated under subparagraph (B) were greater than the hospital’s operating costs of inpatient hospital services determined without regard to this paragraph for a cost reporting period, then the Secretary was to reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this title (taking into account any limitation under subsection (a) of this section) for the period by the amount by which (i) the amount that would have been paid the hospital if (I) the amount of the operating costs of inpatient hospital services estimated under subparagraph (B) were treated as the amount of the operating costs of inpatient hospital services and (II) subsection (a) of this section did not apply to the determination of such amount that would otherwise have been paid the hospital if subsection (a) of this section (and this para-
graph) did not apply, except that, in making such determination for cost reporting periods beginning on or after Oct. 1, 1984, clause (i) of paragraph (1)(B) was to continue to apply.

Subsec. (b)(6)(C). Pub. L. 97–148, § 308(b)(15), substituted ‘‘under this subchapter (taking into account any limitation under subsection (a) of this section)’’ for ‘‘under this subchapter’’ in provisions preceding cl. (i).

Subsec. (c)(1). Pub. L. 98–21, § 301(c)(1), added subpars. (D) and (E) and provisions following subpar. (E).

Subsec. (c)(3)(A). Pub. L. 98–21, § 301(c)(2)(A), substituted ‘‘meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5),’’ for ‘‘meets the requirements of paragraph (1)(A).’’

Subsec. (c)(3)(B). Pub. L. 98–21, § 301(c)(2)(B), inserted ‘‘(or, if applicable, in paragraph (5))’’.

Subsec. (c)(4) to (6). Pub. L. 98–21, § 301(c)(3), added pars. (4) to (6).

Subsec. (d). Pub. L. 98–21, § 301(d)(2), (e), added subsec. (d) and redesignated former subsec. (d), relating to the elimination of lesser-of-cost-or-charges provisions, as subsec. (j) of section 1814 of Aug. 14, 1935, which is classified to subsec. (j) of section 1395f of this title.

Subsecs. (e) to (g). Pub. L. 98–21, § 301(e), added subsecs. (e) to (g).


EFFECITIVE DATE OF 1999 AMENDMENT


‘‘The amendments made by subsection (a) [amending this section] apply to cost reporting periods beginning on or after October 1, 1999.’’

Pub. L. 106–113, div. B, § 1000(a)(6) [title I, § 125(c)], Nov. 29, 1999, 113 Stat. 1556, 1501A–331, provided that:

‘‘The amendments made by subsection (a) [amending this section] are effective as if included in the enactment of section 4421(a) of BBA [the Balanced Budget Act of 1997, Public L. 105–33].’’


‘‘The amendments made by subsection (a) [amending this section] apply with respect to discharges occurring on or after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act [Nov. 29, 1999].’’

Amendment by section 1000(a)(6) [title III, § 321(b), (e), (f), (h), (k)(15)–(17)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395f of this title.

Amendment by section 1000(a)(6) [title IV, § 401(a)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, § 401(c)] of Pub. L. 106–113, set out as a note under section 1395f of this title.

Amendment by section 1000(a)(6) [title IV, § 402(b)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, § 402(b)] of Pub. L. 106–113, set out as a note under section 1395f of this title.

Amendment by section 4417(a)(2) of Pub. L. 105–33 provided that:

‘‘The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1997.’’

Section 4417(b)(2) of Pub. L. 105–33 provided that:

‘‘The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Aug. 5, 1997].’’

Section 4417(a)(2) of Pub. L. 105–33 provided that:

‘‘The amendments made by subsection (a) and (c) [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1997.’’

Amendment by section 4405(d) of Pub. L. 105–33 provided that:

‘‘The amendments made by this section [amending this section] apply to combined medical residency training programs in effect for residency years beginning on or after October 1, 1997.’’

Section 4405(d) of Pub. L. 105–33 provided that:

‘‘The amendments made by this section [amending this section] apply to discharges occurring on or after September 30, 1997.’’

Section 4627(b) of Pub. L. 105–33 provided that:

‘‘The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1996.’’

Section 4417(b)(2) of Pub. L. 105–33 provided that:

‘‘The amendments made by section (a) [amending this section] apply to combined medical residency training programs in effect for residency years beginning on or after October 1, 1997.’’

Section 4417(b)(2) of Pub. L. 105–33 provided that:

‘‘The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after April 1, 2000.’’

Section 13501(b)(3) of Pub. L. 103–66 provided that:

‘‘The amendment made by paragraph (1) [amending this
Section 1395ww

**Effective Date of 1989 Amendment**

Section 6003(a)(2) of Pub. L. 101–239 provided that:

- The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1989.

Section 6003(c)(4) of Pub. L. 101–239 provided that:

- The amendments made by subsection [amending this section] shall apply with respect to discharges occurring on or after April 1, 1990.

Section 6003(b)(7) of Pub. L. 101–239 provided that:

- The amendments made by paragraphs (3) and (4) [amending this section] shall apply to discharges occurring on or after April 1, 1990.

Section 6004(a)(3) of Pub. L. 101–239 provided that:

- The amendments made by this subsection [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that—
  - (A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment or research on cancer under section 1886(d)(5)(I) of the Social Security Act [subsec. (d)(5)(I) of this section] (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act [Dec. 19, 1989], such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification, and
  - (B) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act [section 1815(e)(2) of this title].

Section 6004(b)(2) of Pub. L. 101–239 provided that:

- The amendments made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 1989.

Section 6011(d) of Pub. L. 101–239, as amended by Pub. L. 103–66, amendment by Pub. L. 103–33, title IV, §4452, Aug. 5, 1997, 111 Stat. 425, provided that: “The amendments made by subsection (a) [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except such amendments shall take effect on the date of enactment of this Act [Dec. 19, 1989] and on or before September 30, 1990, and on or after October 1, 1991.”

Section 6004(b)(2) of Pub. L. 101–239 provided that: “The amendments made by subsection (a) [amending this section] shall become effective with respect to cost reporting periods beginning on or after April 1, 1990.”

**Effective Date of 1988 Amendments**

Amendment by section 1018(r)(1) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.


Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, is effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference.
to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

**Effective Date of 1987 Amendments**

Section 4002(g) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(1)(I), July 1, 1988, 102 Stat. 769, provided that:

“(A) the amendments made by subsections (a) and (c) [amending this section] shall apply to payments made under section 1886(d)(1)(A)(III) of the Social Security Act [subsec. (d)(1)(A)(III) of this section] on the basis of discharges occurring on or after April 1, 1988, and

“(B) for discharges occurring on or after October 1, 1988, the applicable percentage increase (described in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1988 is deemed to have been such percentage increase as amended by subsection (a).

“(2) PSFS sole community hospitals—hospital specific portion of payment.—In the case of a subsection (d) hospital which receives payments made under section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section] because it is a sole community hospital—

“(A) the amendments made by subsections (a) and (c) [amending this section] shall apply to payments made under section 1886(d)(1)(A)(I) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital’s cost reporting period beginning on or after October 1, 1987.

“(B) notwithstanding subparagraph (A), for cost reporting period beginning during fiscal year 1988, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for the—

“(i) first 51 days of the cost reporting period shall be 0 percent,

“(ii) next 132 days of such period shall be 2.7 percent,

“(iii) remainder of such period shall be the applicable percentage increase (as so defined, as amended by subsection (a)); and

“(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined, as amended by subsection (a)); and

“(3) PSFS-exempt hospitals.—In the case of a hospital that is not a subsection (d) hospital—

“(A) the amendments made by subsection (e) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987;

“(B) notwithstanding subparagraph (A), for the hospital’s cost reporting period beginning during fiscal year 1988, payment under title XVIII of the Social Security Act [this subchapter] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section] were equal to the product of 2.7 percent and the ratio of 315 to 366; and

“(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1988 shall be deemed to have been 2.7 percent.

“(4) Definition. Regional floor, and technical and conforming amendments.—The amendments made by subsections (b) and (d) and paragraphs (1) and (2) of subsection (f) [amending this section and provisions set out as a note below] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

“(5) Transition for large urban area rates.—In computing the average standardized amount for hospitals located in a large urban area or other urban area under section 1886(d)(3)(A)(ii) of the Social Security Act [subsec. (d)(3)(A)(ii) of this section] (as amended by section (c) for fiscal year 1988, the reference to ‘the respective average standardized amount computed for the previous fiscal year under this subparagraph’ is deemed a reference to the average standardized amount computed in an urban area for the 51-day period beginning on October 1, 1987.

“(6) Definition.—In this subsection, the term ‘subsection (d) hospital’ has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [subsec. (d)(1)(B) of this section]."

Section 4003(e) of Pub. L. 100–203 provided that: “The amendments made by this section [amending this section] shall apply to payments for discharges occurring on or after October 1, 1988.”

Section 4005(a)(3) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(4)(C)(ii), July 1, 1988, 102 Stat. 770, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to discharges occurring on or after April 1, 1988.”

Section 4006(b)(3) of Pub. L. 100–203 provided that: “The amendment made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after April 1, 1988.”

Section 4007(b)(2) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(6)(B), July 1, 1988, 102 Stat. 770, provided that: “The amendment made by paragraph (1)(C) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1989.”

Section 4009(d)(2) of Pub. L. 100–203 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to appointments made after the date of the enactment of this Act [Dec. 22, 1987].”

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1395a–7 of this title.

**Effective Date of 1988 Amendments**


Amendment by section 1895(b)(3), (9) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section
1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Section 9320(a)(3) of Pub. L. 99–509 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act [subsec. (d) of this section], the case of a subsection (d) hospital (as defined in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for the—

(i) first 7 months of the cost reporting period shall be 5 percent; and

(ii) for the remaining 5 months of the cost reporting period shall be 5 percent.

(B) Notwithstanding subparagraph (A), for the cost reporting period beginning during fiscal year 1986, the applicable percentage increase (as so defined with respect to the previous cost reporting period) shall be 5 percent.

(C) For cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been 5 percent.

(4) PPNS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

"(A) the amendment made by subsection (b) [amending this section] shall apply to payments for discharges occurring on or after October 1, 1985;

"(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1986, payment under title XVIII of the Social Security Act (this subchapter) shall be made at the applicable percentage increase described in section 1886(b)(3)(B) [subsec. (b)(3)(B) of this section] equal to 3/4 of 1 percent; and

"(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been 1 1/2 percent.

(5) DEFINITION.—In this subsection, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [subsec. (d)(1)(B) of this section].

Section 9012(d) of Pub. L. 99–272 provided that:

"(1) DELAY IN FINAL TRANSITION.—The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986]."

"(2) CHANGE IN HOSPITAL SPECIFIC PERCENTAGE.—The amendments made by subsection (b) [amending this section] shall apply—

(A) to cost reporting periods beginning on or after October 1, 1985, but

(B) notwithstanding subparagraph (A), for a hospital's cost reporting period beginning during fiscal year 1986, for purposes of section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section].

"(1) during the first 7 months of the period the 'target percentage' is 50 percent and the 'DRG percentage' is 50 percent; and

"(ii) during the remaining 5 months of the period the 'target percentage' is 45 percent and the 'DRG percentage' is 5 percent.

(3) CHANGE IN BLENDED RATE.—The amendments made by subsection (c) [amending this section] shall apply to discharges occurring on or after May 1, 1986.

"(4) EXCEPTION.—

(A) Notwithstanding any other provision of this subsection, the amendments made by this section [amending this section] shall not apply to payments with respect to the operating costs of inpatient hospital services (as defined in section 1886(a)(4) of the Social Security Act [subsec. (a)(4) of this section]) of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act [subsec. (d)(1)(B) of this section]) located in the State of Oregon.

(B) Notwithstanding any other provision of law, for a cost reporting period beginning during fiscal year 1986 of a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply, for purposes of section 1886(d)(1)(A) of such Act [subsec. (d)(1)(A) of this section].
“(1) during the first 7 months of the period the
‘target percentage’ is 50 percent and the ‘DRG per-
centage’ is 25 percent, and
(2) during the remaining 5 months of the period
the ‘target percentage’ is 25 percent and the ‘DRG
percentage’ is 12.5 percent.

(C) Notwithstanding any other provision of law,
for purposes of section 1395xw(a)(1)(D) of such Act [sub-
sec. (d)(1)(D) of this section], the applicable combined
adjusted DRG prospective payment rate for a sub-
section (d) hospital to which the amendments made
by this section [amending this section] do not apply
is, for discharges occurring on or after October 1,
1985, and before May 1, 1986, a combined rate consist-
ing of 25 percent of the national adjusted DRG pro-
spective payment rate and 75 percent of the regional
adjusted DRG prospective payment rate for such dis-
charges.

Section 9104(c) of Pub. L. 99–272 provided that:
‘‘(1) Except as provided in paragraph (2), the amend-
ments made by this section [amending this section] shall
apply to discharges occurring on or after May 1,
1986.

‘‘(2) The amendments made by this section shall not
first be applied to discharges occurring as of a date un-
less, for discharges occurring on that date, the amend-
ments made by section 9105 [amending this section] are
also being applied.’’

Section 9105(e) of Pub. L. 99–272 provided that: ‘‘The amendments made by this section [amending this
section] shall apply to discharges occurring on or after
May 1, 1986.’’

Section 9106(b) of Pub. L. 99–272 provided that: ‘‘The amendment made by subsection (a) [amending this
section] shall apply to cost reporting periods beginning on
or after January 1, 1986.’’

Section 9107(c)(1) of Pub. L. 99–272 provided that:
‘‘The amendments made by subsection (a) [amending this
section] shall apply to hospital cost reporting peri-
ods beginning on or after October 1, 1986.’’

Section 9109(b) of Pub. L. 99–272 provided that: ‘‘The amendment made by subsection (a) [amending this
section] shall take effect on the date of the enactment of
this Act [Apr. 7, 1986].’’

Section 9111(b) of Pub. L. 99–272 provided that: ‘‘The amendment made by this section [amending this
section] shall apply to payments for cost reporting peri-
ods beginning on or after October 1, 1983, and before Oc-
tober 1, 1989.

Section 9202(b) of Pub. L. 99–272 provided that: ‘‘The amendment made by subsection (a) [amending this
section] shall apply to hospital cost reporting periods be-
ginning on or after July 1, 1985.’’

Effective and Termination Dates of 1984 Amendments

Amendment by Pub. L. 98–617 effective as if originally
included in the Deficit Reduction Act of 1984, Pub. L.
98–369, see section 3(c) of Pub. L. 98–617, set out as a
note under section 1395f of this title.

Section 2307(b)(2) of Pub. L. 98–369 provided that:
‘‘The amendment made by paragraph (1) [amending this
section] shall apply to cost reporting periods begin-
ing on or after October 1, 1984.’’

Section 2310(b) of Pub. L. 98–369 provided that: ‘‘The amendments made by this section [amending this
section] shall apply to cost reporting periods beginning in,
and discharges occurring in, fiscal year 1985 and there-
after.’’

Section 2311(d) of Pub. L. 98–369 provided that:
‘‘(1) Except as provided in paragraph (2), the amend-
ments made by subsections (b) and (c) [amending this
section] shall be effective with respect to cost report-
ning periods beginning in or after September 1983, and
the amendment made by subsection (a) [amending this
section] shall be effective with respect to cost report-
ning periods beginning on or after October 1, 1984.

‘‘(2) The amendment made by subsection (b) [amend-
ing this section] shall not apply so as to reduce any
payment under section 1886(d) of the Social Security
Act [subsec. (d) of this section] to a hospital the region of
which is deemed to be changed pursuant to such amend-
ment for discharges occurring in any cost report-
ing period beginning before September 1983.’’

Section 2312(c) of Pub. L. 98–369, as amended by Pub.
1933, Pub. L. 100–360, title IV, § 411(p), July 1, 1988, as added by Pub. L. 100–465, title V, § 505(d)(29), Oct. 15, 1988, 102 Stat. 2324, provided that: ‘‘The amendments made by subsections (a) and (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984, and before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.’’

Amendment by section 2313(a), (b), (d) of Pub. L.
98–369 effective July 1, 1984, see section 2313(e) of Pub.
L. 98–369, set out as an Effective Date of 1984 Amend-
ment note under section 1395yy of this title.

Section 2313(g) of Pub. L. 98–369 provided that: ‘‘The amendments made by this section [amending this
section and sections 1395l–2 and 1395cc of this title and en-
acting and amending provisions set out as notes under
this section] shall be effective as though they had been
enacted in the enactment of the Social Security Amend-
ments of 1983 (Public Law 98–21).’’

Amendment by section 2353(b)(2)(A) of Pub. L.
98–369 effective July 1, 1984, but not to be construed as
changing or affecting any right, liability, status, or in-
terpretation which existed (under the provisions of law
involved) before that date, see section 2354(e)(1) of Pub.
L. 98–369, set out as an Effective Date of 1984 Amend-
ment note under section 1395aa–1 of this title.

Effective Date of 1983 Amendments

Section 601(b)(9) of Pub. L. 98–21 provided that the re-
peal of subsec. (b)(6) of this section is effective with re-
spect to cost reporting periods beginning on or after
October 1, 1982, and that the enactment of a new subsec.
(b)(6) of this section is effective with respect to cost re-
porting periods beginning on or after October 1, 1983.

Section 604 of title VI of Pub. L. 98–21, as amended by
98 Stat. 1960, provided that:

‘‘(a)(1) Except as provided in section 602(l) [amending
section 1395cc of this title] and in paragraph (2), the
amendments made by the preceding provisions of this
section [amending this section and sections 1320c–2, 1395f,
1395m, 1395x, 1395y, 1395cc, 1395mm, 1395oc, and
1395xxc of this title] apply to items and services fur-
nished by or under arrangements with a hospital begin-
ning with its first cost reporting period that begins
on or after October 1, 1983. A change in a hospital’s cost
reporting period that has been made after November 1982
shall be recognized for purposes of this section only if
the Secretary finds good cause for that change.

‘‘(2) Section 1866(a)(1)(F) of the Social Security Act
[section 1395cc(a)(1)(F) of this title] (as added by sec-
section 602(l)(C) of this title), section 1862(a)(14) [section
1395yy(a)(14) of this title] (as added by section 602(e)(3)
of this title) and sections 1886(a)(1)(G) and (H) of such
Act (probably should be section 1866(a)(1)(G) and (H) which
is classified to section 1395cc(a)(1)(G) and (H) of this
section] (as added by section 602(f)(1)(C) of this title) take
effect on October 1, 1983.

‘‘(b) The Secretary shall make an appropriate reduc-
tion in the payment amount under section 1886(d) of
the Social Security Act [subsec. (d) of this section] (as
amended by this title) for any discharge, if the admis-
sion has occurred before a hospital’s first cost report-
ning period that begins after September 1983, to take
into account amounts payable under title XVII of that
Act [this subchapter] (as in effect before the date of the
enactment of this Act [Apr. 20, 1983]) for items and
services furnished before that period.

‘‘(c)(1) The Secretary shall cease to be published in the
Federal Register a notice of the interim final DRG
prospective payment rates established under subsection
(d) of section 1886 of the Social Security Act [subsec. (d) of this section] as amended by this title) no later than September 1, 1983, and allow for a period of public comment thereon. Payment on the basis of prospective rates shall become effective on October 1, 1983, without the necessity for consideration of comments received, but the Secretary shall, by notice published in the Federal Register, affirm or modify the amounts by December 31, 1983, after considering those comments.

“(2) A modification under paragraph (1) that reduces a prospective payment rate shall apply only to discharges occurring after 30 days after the date the notice of the modification is published in the Federal Register.

“(3) Rules to implement the amendments made by this title [amending this section and sections 1395b, 1395c, 1395x, 1395y, 1395s, 1395t, and 1395xx of this title, enacting provisions set out as notes under sections 1395x and 1395xx of this title, and amending provisions set out as a note under section 1395x of this title] shall be established in accordance with the procedure described in this subsection.

“Payment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982. Pub. L. 97–248, see section 309C(c)(2) of Pub. L. 97–448, set out as a note under section 428-1 of this title.

Effective Date
Section 101(b)(1) of Pub. L. 97–248 provided that: ‘‘The amendments made by subsection (a) [enacting this section and amending section 1395x of this title] shall apply to cost reporting periods beginning on or after October 1, 1983.’’

Regulations
Section 4003(c) of Pub. L. 101–508 provided that: ‘‘The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement such amendments [amending this section and enacting provisions set out as a note above].

Section 2315(c)(2) of Pub. L. 98–969 provided that: ‘‘Notwithstanding section 604(c) of the Social Security Amendments of 1983 [section 604(c) of Pub. L. 98–21, set out above], the Secretary of Health and Human Services shall cause to be published in the Federal Register proposed regulations to carry out such subsection not later than October 1, 1983, as amended by the Tax Equity and Fiscal Responsibility Act of 1982.’’

Section 101(b)(2)(A) of Pub. L. 97–248 provided that: ‘‘The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement such amendments [amendments by section 101(a) of Pub. L. 97–248, enacting this section and amending section 1395x of this title] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than March 31, 1983.’’

Transfer of Functions
Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

Special Payments To Maintain 6.5 Percent IMPAYMENT For Fiscal Year 2000

“(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if ‘c’ in clause (ii)(IV) of such section equaled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

“(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d)).’’

Data Collection

“(1) IN GENERAL.—The Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under paragraph (1) in cost reports for cost reporting periods beginning on or after October 1, 2001.’’

Per Discharge Prospective Payment System for Long-Term Care Hospitals

“(a) DEVELOPMENT OF SYSTEM.—

“(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(IV) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(IV)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

“(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

“(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a).’’

“(c) IMPLEMENTATION OF ADDITIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary
shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).”

PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS


“(a) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

“(b) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

“(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.”

STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §125(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–331, provided that:

“(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)).

“(b) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.”

MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS


“(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment policy with respect to professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

“(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under subsection (a).”

CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS

Section 4202(b) of Pub. L. 105–33 provided that:...
“(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

“(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(3)(D) of the Social Security Act [subsec. (d)(8)(D) of this section] shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act [subsec. (d)(10) of this section].”

HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS

Section 4203 of Pub. L. 105–33 provided that:

“(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(10)(C)] of a hospital described in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)] to change the hospital’s geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act [42 U.S.C. 1395ww(d)(5)(F)].

“(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subparagraph (B) and neither subparagraph (A) shall affect payment for discharges for any hospital described as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(3)(D) of the Social Security Act [subsec. (d)(8)(D) of this section] for fiscal year 1998 and each subsequent fiscal year.

“(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(3)(D) of the Social Security Act [subsec. (d)(8)(D) of this section] for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

“(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(3)(D) of the Social Security Act [subsec. (d)(8)(D) of this section] shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act [subsec. (d)(10) of this section].”

TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS


“(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

“(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act [subsec. (d) of this section] for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B)(i)(XIII)] had been increased by 0.5 percentage points; and

“(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B)(i)(XIII)] had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B) and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement (D) of the Secretary after the close of the fiscal year.

“(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

“(A) that is described in paragraph (3) for such period;

“(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of such Act [subsec. (d) of this section] for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1996 is less than the aggregate allowable operating costs of hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting period; and

“(C) with respect to which the payments under section 1886(d) of such Act [42 U.S.C. 1395ww(d)] for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the allowable operating costs of hospital services (as defined in section 1886(a)(4) of such Act [42 U.S.C. 1395ww(a)(4)]) for such hospital for such period, as estimated by the Secretary.

“(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)] that—

“(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act [42 U.S.C. 1395ww(d)(5)(F)] for discharges occurring during the period;

“(B) is not receiving any additional payment under section 1886(d)(5)(A) of such Act [42 U.S.C. 1395ww(d)(5)(A)] or a payment under section 1886(b) of such Act [42 U.S.C. 1395ww(b)] for discharges occurring during the period; and

“(C) does not qualify for payment under section 1886(d)(5)(G) of such Act [42 U.S.C. 1395ww(d)(5)(G)] for the period.”

FORMULA FOR ADDITIONAL PAYMENT AMOUNTS; REPORT

Section 4403(b), (c) of Pub. L. 105–33 provided that:

“(1) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997] and ending 30 months after such date—

“(A) establish a single threshold for costs incurred by hospitals serving low-income patients, and

“(B) consider the costs described in paragraph (3).

“(3) The costs described in this paragraph are as follows:

“(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act [part A of this subchapter] (excluding any supplementation of those benefits by a State under section 1616 of such Act [42 U.S.C. 1382e]).

“(B) The costs incurred by the hospital during a period (as so determined by furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act [subchapter X of this chapter] (excluding any supplementation of those benefits by a State under section 1115 of such Act [42 U.S.C. 1315]).

“(C) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Welfare...
Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula.

**Geographic Reclassification for Certain Disproportionately Large Hospitals**

Section 4409 of Pub. L. 105-33 provided that:

(a) New Guidelines for Reclassification.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

(b) Hospitals Covered.—A hospital described in this subsection is a hospital that demonstrates that—

(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

(2) not less than 40 percent of the adjusted undiscounted wages paid by all hospitals located in such area are attributable to wages paid by the hospital; and

(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years.

**Floor on Area Wage Index**

Section 416 of Pub. L. 105-33 provided that:

(a) In General.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) Implementation.—The Secretary of Health and Human Services shall adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services at such hospitals are not greater or less than those which would have been made in the year if this section did not apply.

(c) Exclusion of Certain Wages.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act [subsec. (d)(10) of this section] for fiscal year 1998, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusions required by this section, on payment of the amount otherwise required by this section, been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

**Report on Effect of Amendments by Pub. L. 105-33, §4415, on Psychiatric Hospitals**

Section 4415(d) of Pub. L. 105-33 provided that: "Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i))) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.)."

**Treatment of Certain Cancer Hospitals: Payment**

Section 4418(b) of Pub. L. 105-33 provided that:

1. Application to Cost Reporting Periods.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1999.

2. Base Year.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act shall be either—

(A) the hospital's cost reporting period beginning during fiscal year 1999, or

(B) pursuant to an election under section 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413, the period provided for under such section.

3. Deadline for Payments.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Aug. 5, 1997].

**Report on Exceptions**

Section 4419(b) of Pub. L. 105-33 provided that: "The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year."

**Development of Proposal on Payments for Long-Term Care Hospitals**

Section 4422 of Pub. L. 105-33 provided that:

(a) In General.—

(1) Legislative Proposal.—The Secretary of Health and Human Services shall develop a legislatively proposed amendment to section 1886(d)(10)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(A)) under title XVIII of such Act (42 U.S.C. 1395 et seq.) for the purpose of payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(2) Collection of Data and Evaluation.—In developing the legislative proposal described in paragraph (1), the Secretary—

(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act [subsec. (d) of this section] to apply to payments under the medicare program to long-term care hospitals.

(b) Report.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of
Congress a report that includes the legislative proposal developed under subsection (a)(1).”

Dissemination of Information on High Per Discharge Relative Values for In-Hospital Physicians’ Services

Section 4506 of title IV of Pub. L. 105–33 provided that—

“(a) Determination and Notice Concerning Hospital-Specific Per Discharge Relative Values.—

“(1) In General.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

“(A) the hospital-specific per discharge relative value under subsection (b); and

“(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

“(2) Notice to Subset of Medical Staffs; Evaluation of Responses.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

“(b) Determination of Hospital-Specific Per Discharge Relative Values.—

“(1) In General.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1886(c)(2) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)]) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

“(2) Special Rule for Teaching Hospitals.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

“(A) the average per discharge relative value (as determined under section 1886(c)(2) of such Act [section 1395w–4(c)(2) of this title]) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

“(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

“The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

“(c) Adjustment for Teaching and Disproportionate Share Hospitals.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act [42 U.S.C. 1395ww(d)(5)]. The adjustment for teaching status or disproportionate share shall not be less than zero.

“(c) Definitions.—For purposes of this section:

“(1) Hospital.—The term ‘hospital’ means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)].

“(2) Medical Staff.—An individual furnishing a physician’s service is considered to be on the medical staff of a hospital—

“(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

“(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

“(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital’s governing body, and

“(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual’s clinical privileges, or

“(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

“(3) Physicians’ Services.—The term ‘physicians’ services’ means the services described in section 1848(j)(3) of the Social Security Act [42 U.S.C. 1395w–4(j)(3)].

“(4) Rural Area; Urban Area.—The terms ‘rural area’ and ‘urban area’ have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

“(5) Secretary.—The term ‘Secretary’ means the Secretary of Health and Human Services.

“(6) Teaching Hospital.—The term ‘teaching hospital’ means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act [42 U.S.C. 1395a(b)(6)].”

Incentive Payments Under Plans for Voluntary Reduction in Number of Residents; Relation to Demonstration Projects and Authority; Regulations

Section 4628(b), (c) of Pub. L. 105–33 provided that:

“(b) Relation to Demonstration Projects and Authority.—

“(1) Section 1886(h)(6) of the Social Security Act [subsec. (h)(6) of this section], added by subsection (a), other than subparagraph (F)(i) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

“(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

“(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act [this subchapter] in connection with a reduction in the number of residents in a medical residency training program.

“(c) Interim, Final Regulations.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act [Aug. 5, 1997].”

Demonstration Project on Use of Consortia

Section 4628 of Pub. L. 105–33 provided that:

“(a) In General.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act [subsec. (h) of this section], the Secretary shall
make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children’s hospital.

(C) A Federally qualified health center.

(D) A medical group practice.

(E) A managed care entity.

(F) An entity furnishing outpatient services.

(G) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(5) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(b) or (k) of the Social Security Act [subsecs. (h), (k) of this section] for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act [this subchapter] as the Secretary specifies.

RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Section 4629 of Pub. L. 105–33 provided that:

(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act [section 1395b–6 of this title] and in this section referred to as the ‘‘Commission’’) shall examine and develop recommendations on whether and to what extent Medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children’s hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

(2) Federal policies regarding international medical graduates.

(3) The dependence of schools of medicine on service-generated income.

(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

(6) individuals with expertise in health care payment policies.

(c) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Commission shall submit to the Congress a report providing its findings inappropriate.

STUDY OF HOSPITAL OVERHEAD AND SUPERVISING PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS

Section 4630 of Pub. L. 105–33 provided that:

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(b) of the Social Security Act [subsec. (h) of this section], and

(2) the reasons for such variations.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate.

DRG PROSPECTIVE PAYMENT RATE METHODOLOGY; TRANSITION RULE FOR FISCAL YEAR 1998

Section 4644(a)(2) of Pub. L. 105–33 provided that:

With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term ‘‘60 days’’ in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ‘‘30 days’’.

HOSPITAL PAYMENT UPDATES; TRANSITION RULE FOR FISCAL YEAR 1998

Section 4644(b)(2) of Pub. L. 105–33 provided that:

With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term ‘‘60 days’’ in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ‘‘30 days’’.

GEOGRAPHICAL RECLASSIFICATION; SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997

Section 4644(c)(2) of Pub. L. 105–33 provided that: ‘‘In the case of an application for a change in geographic classification under such section [subsec. (d)(10)(C)(ii) of this section] for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines
under such section so as to permit completion of a final decision by the Secretary by June 15, 1998.’’

No Standardized Amount Adjustments for Fiscal Years 1992 or 1993

Section 13501(b)(2) of Pub. L. 101–66 provided that:

“The Secretary of Health and Human Services shall not revise the fiscal year 1992 or fiscal year 1993 standardized amounts pursuant to subsections to section 1886(d)(3)(B) and (d)(8)(D) of section 1886 of the Social Security Act [subsec. (d)(3)(B) and (d)(8)(D) of this section] to account for the amendment made by paragraph (1) [amending this section].”

Extension of Regional Referral Center Classifications Through Fiscal Year 1994; Reclassification

Section 13501(d) of Pub. L. 101–66 provided that:

“(1) Extension of classification through fiscal year 1994.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] as of September 30, 1992, shall continue to be so classified for cost reporting periods beginning during fiscal year 1993 or fiscal year 1994, unless the area in which the hospital is located is redesignated as a Metropolitan Statistical Area by the Office of Management and Budget for such a fiscal year.

(2) Permitting hospitals to decline reclassification.—If any hospital fails to qualify as a rural referral center under section 1886(d)(5)(C) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993 or fiscal year 1994, the Secretary of Health and Human Services shall—

(A) notify such hospital of such failure to qualify,

(B) provide an opportunity for such hospital to decline such reclassification, and

(C) if the hospital declines such reclassification, administer the Social Security Act [this chapter] (other than section 1886(d)(8)(D)) for such fiscal year.

(3) Requiring lump-sum retroactive payment for hospitals losing classification.—

(A) In general.—In the case of a hospital treated as a medicare-dependent, small rural hospital under section 1886(d)(5)(G) of the Social Security Act, the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886(d)(5)(G)(i) of such Act as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of such Act as a result of a decision by the Review Board had not occurred, or

(B) Period of applicability.—In subparagraph (A), the ‘period of applicability’ is the period that begins on the first day of the hospital’s first 12-month cost reporting period that begins after April 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993].”

Adjustment in GME Base-Year Costs of Federal Insurance Contributions Act

Section 13563(d) of Pub. L. 101–66 provided that:

“(1) In general.—In determining the amount of payment to be made under section 1886(h) of the Social Security Act [subsec. (h) of this section] in the case of a hospital described in paragraph (2) for cost reporting periods beginning on or after October 1, 1992, the Secretary of Health and Human Services shall—

(A) notify such hospital of such failure to qualify,

(B) provide an opportunity for such hospital to decline such reclassification, and

(C) if the hospital declines such reclassification, administer the Social Security Act without regard to subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability described in subparagraph (B) and

(2) Hospitals affected.—A hospital described in this paragraph is a hospital that did not pay FICA taxes with respect to interns and residents in its medical residency training program.

(3) Definitions.—In this subsection:

(A) The ‘base cost reporting period’ for a hospital is the hospital’s cost reporting period, but is required to pay FICA taxes or make contributions to a retirement system described in paragraph (1) with respect to such interns and residents because of the amendments made by section 11322(b) of OBRA–1990 [Pub. L. 101–508, amending section 3121 of Title 26, Internal Revenue Code].

(B) The term ‘FICA taxes’ means, with respect to a hospital, the taxes under section 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3111].”

Determination of Area Wage Index for Discharges Occurring January 1, 1990, to October 1, 1996

Section 4002(d)(1) of Pub. L. 101–508 provided that:

“(A) For purposes of section 1386(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section] for discharges occurring on or after January 1, 1991, and be-
before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

“(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs.”

STUDY AND REPORT ON RELATIONSHIP BETWEEN NON-WAGE-RELATED INPUT PRICES AND ADJUSTED AVERAGE STANDARDIZED AMOUNTS

Section 4002(e)(2) of Pub. L. 101–508 directed Secretary of Health and Human Services to collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under subsec. (d)(9) of this section to identify extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices, and, not later than June 1, 1993, submit a report to Congress analyzing such data, with such report to include recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

DEADLINE FOR SUBMISSION OF APPLICATIONS TO GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Section 4002(h)(2)(A) of Pub. L. 101–508 provided that: “For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act [subsec. (d)(10) of this section] has met the deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section.”

PAYMENTS FOR MEDICAL EDUCATION COSTS

Section 4004 of Pub. L. 101–508 provided that:

“(a) HOSPITAL GRADUATE MEDICAL EDUCATION REIMBURSEMENT.—

“(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act [part A of this subchapter] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [subsec. (h) of this section].

“(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

“(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

“(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

“(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

“(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(a) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1988;

“(b) the proportion of the hospital’s total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

“(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program and

“(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

“(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

“(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its Medicare cost reports for cost reporting periods beginning on or after October 1, 1991, and before October 1, 1996, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as defined by the Secretary pursuant to section 1861(v) of such Act [section 1395x(v) of this title]).

“(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

“(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

“(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.”

Section 4159 of Pub. L. 101–508 provided that:

“(a) HOSPITAL GRADUATE MEDICAL EDUCATION REIMBURSEMENT.—

“(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act [part B of this subchapter] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [subsec. (h) of this section].

“(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

“(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

“(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

“(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under
(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1988;

(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

(3) PROHIBITION AGAINST RECoupMENT OF COSTS BY SECRETARY.—

In general.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act (section 1395x(v) of this title)).

(B) R confines of AMOUNTS RECOUNED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

(4) Special Audit to Determine Costs.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

(5) Effective Date.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1991.

Development of National Prospective Payment Rates for Current Non-FPS Hospitals

Section 4005(b) of Pub. L. 101–508 provided that:

(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (subsection (d)(1)(B) of this section)) receive payment for the operating and capital-related costs of inpatient hospital services under part A [part A of this subchapter] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

(2) REPORT.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

Guidance to Intermediaries and Hospitals

Section 4005(c)(3) of Pub. L. 101–508 provided that:

The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act [section 1395w of this title] and to hospitals that are not subsection (d) hospitals (as defined in section 1866(d)(1)(B) of such Act [subsection (d)(1)(B) of this section]) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act.

Freeze in Payments Under Part A of This Subchapter Through December 31, 1990

Section 4007 of Pub. L. 101–508 provided that:

(a) In General.—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act [part A of this subchapter] (including payments under section 1886 of such Act [this section]) attributable to or allocated under such part during the period described in subsection (b):

(1) the market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period;

(2) the percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(1)(2)(B) of such Act [section 1395w(1)(2)(B) of this title] shall be deemed to be 0.

(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

(b) Description of Period.—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990.
REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS

Section 4008(b)(1) of Pub. L. 101–508 provided that:

"(1) In general.—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act [this subchapter] to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(3)(C) of such Act [subsec. (d)(1)(B) of this section] that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act).

Such review shall specifically include standards related to staffing requirements.

"(2) Report.—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a)."

PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR

Section 4207(b)(1), formerly 4207(b)(1), of Pub. L. 101–508, as renumbered and amended by Pub. L. 103–432, title I, §150(d)(4), (5)(C), Oct. 31, 1994, 108 Stat. 4444, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [this subchapter] in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1995, or, if later, the last fiscal year for which there is a maximum deficit amount specified under section 601(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 [2 U.S.C. 665(a)(1)] of more than $30,000,000, except as follows:

"(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

"(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

"(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute."

PROHIBITION OF PAYMENT CYCLE CHANGES

Section 4207(b)(2), formerly 4207(b)(2), of Pub. L. 101–508, as renumbered by Pub. L. 103–432, title I, §150(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act [Nov. 5, 1990], any final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute."

INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES

Section 6003(a)(3) of Pub. L. 101–239 provided that: "For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1990 is deemed to be such percentage increase as amended by paragraph (1)."

CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS

Section 6003(e)(3) of Pub. L. 101–239 provided that: "Any hospital classified as a sole community hospital under section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section] on the date of the enactment of this Act [Dec. 19, 1989] shall be deemed to have been such percentage increase as amended by paragraph (1)."

ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX

Section 6003(h)(5) of Pub. L. 101–239 provided that: "(A) In general.—If the Secretary of Health and Human Services (hereinafter referred to as the 'Secretary') discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section] and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act (this subchapter) to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.

"(B) Conditions for additional payment.—A hospital is eligible for an additional payment under subparagraph (A) only if—

"(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

"(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and

"(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

"(C) Period of applicability.—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990."

LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS

Section 115(b)(2) of Pub. L. 101–403 provided that: "The Secretary of Health and Human Services shall make any adjustments resulting from the amendment made by paragraph (1) [amending this section] in the amount of the payments made to hospitals under section 1886(d) of the Social Security Act [subsec. (d) of this section] in a fiscal year for the operating costs of an inpatient hospital service in a manner that ensures that the aggregate payments under such section are not greater or less than those that would have been made in the year without such adjustments."

INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES

Section 6003(a)(3) of Pub. L. 101–239 provided that: "For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1990 is deemed to be such percentage increase as amended by paragraph (1)."

Determination and Recommendations of Payments for Costs of Administering Blood Clotting Factors to Individuals With Hemophilia

Section 6011(b), (c) of Pub. L. 101–239 provided that:

“(b) Determining Payment Amount.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act [part A of this subchapter] for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

“(c) Recommendations on Payments.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act [Dec. 19, 1989].”

Publication of Instructions Relating to Exceptions and Adjustments in Target Amounts

Section 6015(b) of Pub. L. 101–239 provided that: “By not later than 180 days after the date of enactment of this Act [Dec. 19, 1989], the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act [subsec. (b)(4)(A) of this section].”

Delay in Recoupment of Certain Nursing and Allied Education Costs

Section 6205(b) of Pub. L. 101–239 provided that:

“(1) The Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act [this subchapter] to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its Medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of ‘operating costs of inpatient hospital services’ pursuant to section 1886(a)(4) of such Act [subsec. (a)(4) of this section], so that no pass-through of such costs was permitted under such section.

“(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

“(B) In issuing such regulations—

“(i) the Secretary shall allow a comment period of not less than 60 days,

“(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

“(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

“(C) Such regulations shall specify—

“(i) the relationship required between an approved nursing or allied health education program and a hospital for the program’s costs to be attributed to the hospital;

“(ii) the types of costs related to nursing or allied health education programs that are allowable by Medicare;

“(iii) the distinction between costs of approved educational activities as recognized under section 1886(c)(2) of the Social Security Act [subsec. (a)(3) of this section] and educational costs treated as operating costs of inpatient hospital services; and

“(iv) the treatment of other funding sources for the program.”

Inner-City Hospital Thalid Demonstration Project


“(a) Establishment.—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year) for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

“(1) to train hospital personnel to operate and participate in the system; and

“(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

“(b) Limitations on Payments.—In making payments under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

“(2) The amount of payment made under the demonstration project during a single year may not exceed $500,000.”

Transition Adjustments to Target Amounts for Inpatient Hospital Services

Section 101(c)(2)(B) of title I of Pub. L. 101–234 provided that: “The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act [subsec. (b)(3)(A) of this section] in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title [see Tables for classification].”

Election of Personnel Policy for ProPAC Employees

Section 405 of Pub. L. 100–647 provided that: “With respect to employees of the Prospective Payment Assessment Commission hired before December 22, 1987, such employees shall have the option to elect, within 60 days of the date of enactment of this Act [Nov. 10, 1988] to be covered under either the personnel policy in effect with respect to such employees before December 22, 1987, or under the employees coverage provided under the last sentence of section 1886(a)(6)(D) of the Social Security Act [subsec. (c)(6)(D) of this section].”

Adjustments in Payments for Inpatient Hospital Services


“(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act [subsec. (d) of this section], outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, and before January 1, 1990, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by (or on behalf of Medicare beneficiaries resulting from the elimination of a day limitation on Medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title].)

“(2) PFS EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security
Act [subsec. (b)(3) of this section] for portions of cost
reporting periods occurring on or after January 1, 1989,
and before January 1, 1990, the Secretary shall, on a
hospital-specific basis, take into consideration the re-
ductions in payments to hospitals by (or on behalf of)
medicare beneficiaries resulting from the elimination of
a day limitation on medicare inpatient hospital serv-
ces (under the amendments made by section 101
[amending section 1395d of this title]), without regard
to whether such a hospital is paid on the basis
described in subparagraph (A) or (B) of section 1886(b)(1)
of such Act, without regard to whether any of such
beneficiaries exhausted medicare inpatient hospital
insurance benefits before January 1, 1989." [Amendment of section 104(c) of Pub. L. 100–360, set
out above, by section 101(c)(1), (2)(A) of Pub. L. 101–234
effective as if included in enactment of Pub. L. 100–360,
see section 101(d) of Pub. L. 101–234, set out as a note
under section 1395c of this title].

PROFAC STUDY
Section 203(c)(2) of Pub. L. 100–360 directed Prospective
Payment Assessment Commission to conduct a
study, and make recommendations to Congress and Secretary of Health and Human Services by not later
than Mar. 1, 1991, concerning appropriate adjustment to
payment amounts provided under subsec. (d) of this
section for inpatient hospital services to account for
reduced costs to hospitals resulting from amendments
made by section 203 of Pub. L. 100–360, taking into
account the factors specified in paragraph (1) of the
Social Security Amendments of 1983 [section 602(k) of
Pub. L. 98–21, set out as a note under section 1395y of
the Social Security Act [subsec. (d) of this section]].

CLINIC HOSPITAL WAGE INDICES
Section 4004(b) of Pub. L. 100–203 provided that: "In
calculating the wage index under section 1886(d) of the
Social Security Act [subsec. (d) of this section] for
purposes of making payment adjustments after September
30, 1988, as required under paragraphs (2)(H) and (3)(E)
of section, in the case of any institution which re-
ceived the waiver specified in section 602(k) of the So-
cial Security Amendments of 1983 [section 602(k) of
Pub. L. 98–21, set out as a note under section 1395y of
this title], the Secretary of Health and Human Services
shall include wage costs paid to related organization
employees directly involved in the delivery and admin-
istration of care provided by the related organization
to hospital inpatients. For purposes of the preceding
sentence, the term 'wage costs' does not include costs
of overhead or home office administrative salaries or
any costs that are not incurred in the hospital's Metro-

POLITICALLY STATISTICAL AREA."

LIMITATION ON AMOUNTS PAID IN FISCAL YEARS 1988
AND 1989
Section 4005(c)(2)(B) of Pub. L. 100–203 provided that:
"(B) The Secretary of Health and Human Services shall
take appropriate steps to ensure that the total amount
paid in a fiscal year under title XVIII of the Social Se-
curity Act [this subchapter] by reason of the amend-
ment made by paragraph (1)(B) [amending this section]
does not exceed $5,000,000 in the case of fiscal year 1988
and $10,000,000 for fiscal year 1989."

STUDY OF CRITERIA FOR CLASSIFICATION OF HOSPITALS
AS RURAL REFERRAL CENTERS; REPORT
Section 4005(d)(2) of Pub. L. 100–203 directed Secretary
of Health and Human Services to provide for a study of
the criteria used for the classification of hospitals as
rural referral centers, and report to Congress, by not
later than Mar. 1, 1989, on the study and on recom-
endations for the criteria that should be applied for the
classification of hospitals as rural referral centers for
cost reporting periods beginning on or after Oct. 1,
1989.

GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION
Section 4005(e) of Pub. L. 100–203, as amended by Pub.
Stat. 2150; Pub. L. 103–432, title I, §103(a)(1), (b), (c),
Oct. 31, 1994, 108 Stat. 4404, 4405, provided that:
"(1) The Administrator of the Health Care Financing
Administration, in consultation with the Assistant
Secretary for Health (or a designee), shall establish
a program of grants to assist eligible small rural hos-
itals and their communities in the planning and im-
plementation of projects to modify the type and extent
of services such hospitals provide in order to adjust for
one or more of the following factors:

(A) Changes in clinical practice patterns.

(B) Changes in service populations.

(C) Declining demand for acute-care inpatient hos-
pital capacity.

(D) Declining ability to provide appropriate staffing
for inpatient hospitals.

(E) Increasing demand for ambulatory and emer-
gency services.

(F) Increasing demand for appropriate integration
of community health services.

(G) The need for adequate access (including appro-
priate transportation) to emergency care and inpa-
tient care in areas in which a significant number of
underutilized hospital beds are being eliminated.

(H) The Administrator shall submit a final report
on the program to the Congress not later than 180
days after all projects receiving a grant under the
program are completed.

Each demonstration project under this subsection shall demonstrate methods of strengthening the financial
and managerial capability of the hospital involved to
provide necessary services. Such methods may include
programs of cooperation with other health care provid-
ers, of diversification in services furnished (including
the provision of home health services), of physician re-
cruitment, and of improved management systems.

Grants under this paragraph may be used to provide in-
struction and consultation (and such other services as
the Administrator determines appropriate) via tele-
communications to physicians in such rural areas
(within the meaning of section 1886(d)(2)(D) of the So-
cial Security Act [subsec. (d)(2)(D) of this section])
as are designated either class 1 or class 2 health manpower
shortage areas under section 332(a)(1)(A) of the Public
Health Service Act [section 254a(a)(1)(A) of this title].

(2) For purposes of this subsection, the term 'eligi-
sable small rural hospital' means any rural primary care
hospital designated by the Secretary under section
1820(1)(2) of the Social Security Act [section 1395i–4(i)(2)
of this title], or any non-Federal, short-term general
acute care hospital that:--

(A) is located in a rural area (as determined in ac-
cordance with subsection (d)),

(B) has less than 100 beds, and

(C) is not for profit.

(3)(A) Any eligible small rural hospital that desires
to modify the type or extent of health care services
that it provides in order to adjust for one or more of
the factors specified in paragraph (1) may submit an
application pursuant to subparagraph (A).

(3)(B) The Secretary for Health (or a designee), shall establish a
program of grants to assist eligible small rural hos-
pitals and their communities in the planning and im-
plementation of projects to modify the type and extent
of services such hospitals provide in order to adjust for
one or more of the following factors:

(A) Changes in clinical practice patterns.

(B) Changes in service populations.

(C) Declining demand for acute-care inpatient hos-
pital capacity.

(D) Declining ability to provide appropriate staffing
for inpatient hospitals.

(E) Increasing demand for ambulatory and emer-
gency services.

(F) Increasing demand for appropriate integration
of community health services.

(G) The need for adequate access (including appro-
priate transportation) to emergency care and inpa-
tient care in areas in which a significant number of
underutilized hospital beds are being eliminated.

(H) The Administrator shall submit a final report
on the program to the Congress not later than 180
days after all projects receiving a grant under the
program are completed.

Each demonstration project under this subsection shall demonstrate methods of strengthening the financial
and managerial capability of the hospital involved to
provide necessary services. Such methods may include
programs of cooperation with other health care provid-
ers, of diversification in services furnished (including
the provision of home health services), of physician re-
cruitment, and of improved management systems.

Grants under this paragraph may be used to provide in-
struction and consultation (and such other services as
the Administrator determines appropriate) via tele-
communications to physicians in such rural areas
(within the meaning of section 1886(d)(2)(D) of the So-
cial Security Act [subsec. (d)(2)(D) of this section])
as are designated either class 1 or class 2 health manpower
shortage areas under section 332(a)(1)(A) of the Public
Health Service Act [section 254a(a)(1)(A) of this title].

"(2) For purposes of this subsection, the term 'eligi-
sable small rural hospital' means any rural primary care
hospital designated by the Secretary under section
1820(1)(2) of the Social Security Act [section 1395i–4(i)(2)
of this title], or any non-Federal, short-term general
acute care hospital that:

(A) is located in a rural area (as determined in ac-
cordance with subsection (d)),

(B) has less than 100 beds, and

(C) is not for profit.

(3)(A) Any eligible small rural hospital that desires
to modify the type or extent of health care services
that it provides in order to adjust for one or more of
the factors specified in paragraph (1) may submit an
application pursuant to subparagraph (A).

"(B) The Governor shall transmit to the Adminis-
trator, within a reasonable time after receiving a copy
of an application pursuant to subparagraph (A), any
comments with respect to the application that the Gov-
ernor deems appropriate.

"(C) The Governor of a State may designate an appro-
priate State agency to receive and comment on applica-
tions submitted under subparagraph (A).

"(D) A hospital shall be considered to be located in a rural area for purposes of this subsection if it is treated
as being located in a rural area for purposes of section
1866(d)(3)(D) of the Social Security Act [subsec. (d)(3)(D) of this section].
“(5) In determining which hospitals making applica-
tion under paragraph (3) will receive grants under this
subsection, the Administrator shall take into ac-
count—

"(A) any comments received under paragraph (3)(B)
with respect to a proposed project;

"(B) the effect that the project will have on—

"(i) reducing expenditures from the Federal Hos-
ital Insurance Trust Fund,

"(ii) improving the access of Medicare bene-
ficiaries to health care of a reasonable quality;

"(C) the extent to which the proposal of the hos-
pital, using appropriate data, demonstrates an under-
standing of—

"(i) the primary market or service area of the
hospital, and

"(ii) the health care needs of the elderly and dis-
abled that are not currently being met by providers
in such market or area, and

"(D) the degree of coordination that may be ex-
pected between the proposed project and—

"(i) other local or regional health care providers, and

"(ii) community and government leaders, as
evidenced by the availability of support for the
project (in cash or in kind) and other relevant factors.

"(6) A grant to a hospital under this subsection may
not exceed $50,000 a year and may not exceed a term of
3 years.

"(7)(A) Except as provided in subparagraphs (B) and
(C), a hospital receiving a grant under this subsection
may use the grant for any of expenses incurred in plan-
ning and implementing the project with respect to
which the grant is made.

"(B) A hospital receiving a grant under this subsec-
tion for a project may not use the grant to retire
debt incurred with respect to any capital expenditure
made prior to the date on which the project is initi-
ated.

"(C) Not more than one-third of any grant made
under this subsection may be expended for capital-re-
lated costs (as defined by the Secretary for purposes
of section 1886(a)(4) of the Social Security Act [subsec.-
a(4) of this section]) of the project, except that this
limitation shall not apply with respect to a grant used
for the purposes described in subparagraph (D).

"(8)(A) A hospital receiving a grant under this sec-
tion may be expended for capital-re-
lated costs (as defined by the Secretary for purposes
of section 1886(a)(4) of the Social Security Act [subsec.
a(4) of this section]) of the project, except that this
limitation shall not apply with respect to a grant used
for the purposes described subparagraph (D).

"(B) A hospital may use a grant received under this
subsection to develop a plan for converting itself to a
rural primary care hospital (as described in section 1820
of the Social Security Act [section 1820(g) of such Act])
or to develop a rural health network (as defined in sec-
tion 1820(p) of such Act) in the State in which it is
located if the State is receiving a grant under section
1820a(a)(1).

"(9) A hospital receiving a grant under this sec-
tion (amending this section and section 1395tt of this
title and enacting provisions set out as notes under
section 1395tt of this title) shall fur-

nish the Administrator with such information as the
Administrator may require to evaluate the project with
respect to which the grant is made and to ensure that the
grant is expended for the purposes for which it was
made.

"(B) The Administrator shall report to the Congress
at least once every 12 months on the program of grants
established under this subsection. The report shall as-
sess the functioning and status of the program, shall
evaluate the progress made toward achieving the pur-
poses of the program, and shall include any recom-
endations the Secretary may deem appropriate with
respect to the program. In preparing the report, the
Secretary shall solicit and include the comments and
recommendations of private and public entities with an
interest in rural health care.

"(C) The Administrator shall submit a final report on
the program to the Congress not later than 180 days
after all projects receiving a grant under the program
are completed.

"(9) For purposes of carrying out the program of
grants under this subsection, there are authorized to be
appropriated from the Federal Hospital Insurance Trust Fund $15,000,000 for fiscal year 1988, $25,000,000 for
each of the fiscal years 1990, 1991, and 1992 and $30,000,000 for each of fiscal years 1993 through 1997.”

Section 103(a)(2) of Pub. L. 103–432 provided that:

“The amendment made by paragraph (1) [amending sec-

section 406(e)(2) of Pub. L. 100–203, set out above] shall apply to grants made on or after October 1, 1994.”

[Pub. L. 103–432, §103(c), which directed amendment of
section 406(e)(8)(B) of Pub. L. 100–203, was executed by
amending section 4065(e)(8)(B) of Pub. L. 100–203, set out above, to reflect the probable intent of Congress.]
"(B) to be compatible with the needs of the medicare prospective payment system.

"(4) The Secretary shall prepare and submit, to the Prospective Payment Assessment Commission, the Comptroller General, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, by not later than 45 days after the end of each calendar quarter, data collected under the system.

"(5) In paragraph (2):

"(A) The term 'bad debt and charity care' has such meaning as the Secretary establishes.

"(B) The term 'class' means, with respect to payers at least, the programs under this title XVIII of the Social Security Act [this subchapter], a State plan approved under title XIX of such Act (subchapter XIX of this chapter), other third-party payers, and other persons (including self-paying individuals).

"(6) The Secretary shall set aside at least a total of $3,000,000,000 for fiscal years 1988, 1989, and 1990 from existing research funds or from operations funds to develop the format, according to paragraph (1) and for data collection and analysis, but total funds shall not exceed $15,000,000.

"(7) The Comptroller General shall analyze the adequacy of the existing systems for reporting of hospital information and the costs and benefits of data reporting under the demonstration system and will recommend improvements in hospital data collection and analysis and display of data in support of policy making.

"(d) Consultation.—The Secretary shall consult representatives of the hospital industry in carrying out the provisions of this section.

HOSPITAL OUTLIER PAYMENTS AND POLICY

Section 4008(d) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(7), July 1, 1988, 102 Stat. 771, provided that:

"(1) INCREASE IN OUTLIER PAYMENTS FOR BURN CENTER DRG.—

"(A) IN GENERAL.—For discharges classified in diagnosis-related groups relating to burn cases and occurring on or after April 1, 1988, and before October 1, 1989, the marginal cost of care permitted by the Secretary of Health and Human Services under section 1886(d)(5)(A)(ii) of the Social Security Act [subsec. (d)(5)(A)(ii) of this section] shall be 90 percent of the appropriate per diem cost of care or 90 percent of the cost for cost outliers.

"(B) BUDGET NEUTRALITY.—Subparagraph (A) shall be implemented in a manner that ensures that total payments under section 1886(d) of the Social Security Act are not increased or decreased by reason of the adjustments required by such subparagraph.

"(2) LIMITATION ON CHANGES IN OUTLIER REGULATIONS.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act (Dec. 22, 1987) and before September 1, 1988, any final regulation which changes the method of payment for outlier cases under section 1886(d)(5)(A) of the Social Security Act [subsec. (d)(5)(A) of this section].

"(B) PROPAC REPORT.—The chairman of the Prospective Payment Assessment Commission shall report to Congress and the Secretary of Health and Human Services, by not later than June 1, 1988, on the method of payment for outlier cases under such section and providing more adequate payments for appropriate payments with respect to burn outlier cases.

"(3) REPORT ON OUTLIER PAYMENTS.—The Secretary of Health and Human Services shall include in the annual report submitted to the Congress pursuant to section 1875(b) of the Social Security Act [section 1395ww(b) of this title] a comparison with respect to hospitals located in an urban area and hospitals located in a rural area in the amount of reductions under section 1886(d)(3)(B) of the Social Security Act [subsec. (d)(3)(B) of this section] and additional payments under section 1886(d)(5)(A) of such Act."

PROPAC STUDIES AND REPORTS

Section 4009(b) of Pub. L. 100–203 provided that:

"(1) PROPAC REPORTS ON STUDY OF DRG RATES FOR HOSPITALS IN RURAL AND URBAN AREAS.—The Prospective Payment Assessment Commission shall evaluate the study conducted by the Secretary of Health and Human Services pursuant to section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 (section 603(a)(2)(C)(i) of Pub. L. 98–21, set out below) (relating to the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates) and report its conclusions and recommendations to the Congress not later than March 1, 1988.

"(2) PROPAC REPORT ON SEPARATE URBAN PAYMENT RATES.—The Prospective Payment Assessment Commission shall evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas (as defined in section 1886(d)(2)(D) of the Social Security Act [subsec. (d)(2)(D) of this section]) and in other urban areas, and shall report to Congress on such evaluation not later than January 1, 1989.

"(3) REPORT ON ADJUSTMENT FOR NON-LABOR COSTS.—The Prospective Payment Assessment Commission shall perform an analysis to determine the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts under section 1886(d)(3) of the Social Security Act [subsec. (d)(3) of this section] based on area differences in hospitals' costs (other than wage-related costs) and input prices. The Commission shall report to the Congress on such analysis by not later than October 1, 1989.

SPECIAL RULE FOR URBAN AREAS IN NEW ENGLAND

Section 4009(i) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, §411(b)(8)(C), July 1, 1988, 102 Stat. 771, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into agreements with 10 sponsoring hospitals submitting applications under this subsection to conduct demonstration projects to assist resident physicians in developing field clinical experience in rural areas.

"(b) NATURE OF PROJECT.—Under a demonstration project conducted under subsection (a), a sponsoring hospital entering into an agreement with the Secretary under such subsection shall enter into arrangements with a small rural hospital to provide to such rural hospital, for a period of one to three months of training, physicians (in such number as the agreement under such subsection (a) may provide) who have completed one year of residency training.

"(c) SELECTION.—(1) In selecting from among applications submitted under subsection (a), the Secretary shall ensure that four small rural hospitals located in different counties participate in the demonstration project and that—

"(A) two of such hospitals are located in rural counties of more than 7,500 square miles (one of which is west of the Mississippi River and one of which is west of such river); and
“(B) two of such hospitals are located in rural coun-
ties with (as determined by the Secretary) a severe
shortage of physicians (one of which is east of the
Mississippi River and one of which is west of such
river).

“(2) The provisions of paragraph (1) shall not apply
with respect to applications submitted as a result of
amendments made by section 6216 of the Omnibus
Budget Reconciliation Act of 1989 [Pub. L. 101–239,
amending this note].

“(d) CLARIFICATION OF PAYMENT.—For purposes of sec-
tion 1886 of the Social Security Act [this section]—

“(1) with respect to subsection (d)(5)(B) of such sec-
tion, any resident physician participating in the
project under subsection (a) for any part of a year
shall be treated as if he or she were working at the
appropriate sponsoring hospital with an agreement
under subsection (a) on September 1 of such year (and
shall not be treated as if working at the small rural
hospital); and

“(2) with respect to subsection (h) of such section,
the payment amount permitted under such sub-
section for a sponsoring hospital with an agreement
under subsection (a) shall be increased (for the dura-
tion of the project only) by an amount equal to the
amount of any direct graduate medical education
 costs (as defined in paragraph (5) of such subsection
(h)) incurred by such hospital in supervising the edu-
cation and training activities under a project under
subsection (a).

“(e) DURATION OF PROJECT.—Each demonstration
project under subsection (a) shall be commenced not
later than six months after the date of enactment of
this Act [Dec. 22, 1987] or the date of the enactment
of the Omnibus Budget Reconciliation Act of 1989
[Dec. 19, 1989], in the case of a project conducted as a result of
the amendments made by section 6216 of such Act [Pub.
L. 101–239, amending this note]) and shall be conducted
for a period of three years.

“(f) DEFINITION.—In this section, the term ‘spon-
soring hospital’ means a hospital that receives payments
under sections 1886(d)(5)(B) and 1886(h) of the Social
Security Act [subsecs. (d)(5)(B) and (h) of this section].

PROHIBITION ON POLICY BY SECRETARY OF HEALTH AND
HUMAN SERVICES TO REDUCE EXPENDITURES IN FIS-

Section 4039(d) of Pub. L. 100–203, as amended by Pub.
L. 100–360, title IV, § 426(e), July 1, 1988, 102 Stat. 814;
2245, provided that: ‘‘Notwithstanding any other provi-
sion of law, except as required to implement specific
provisions required under statute, the Secretary of
Health and Human Services is not authorized to issue
in final form, after the date of the enactment of
this Act (Dec. 22, 1987) or the date of the enactment
of the Omnibus Budget Reconciliation Act of 1989
(Dec. 19, 1989), in the case of a project conducted as a result of
the amendments made by section 6216 of such Act [Pub.
L. 101–239, amending this note]) and shall be conducted
for a period of three years.

“(g) EXTENSION OF BLENDED DRG RATE.—For pur-
poses of subsection (d)(1) of such section, the ‘alle-
cable combined adjusted DRG prospective payment rate’ for discharges occurring

“(1) during the extension period is the rate spec-
fied in subsection (d)(1)(D)(ii) of such section, or

“(2) after such period is the national adjusted
prospective payment rate determined under sub-
section (d)(3) of such section.

“(h) EXTENSION OF HOSPITAL-SPECIFIC PAYMENT.—
For the first 51 days of a hospital cost reporting pe-
riod beginning during fiscal year 1988, payment
shall be made under clause (ii) (rather than clause
(iii)) of subsection (d)(1)(A) of such section (subject
to clause (i) of this subparagraph), the target per-
centage and DRG percentage shall be those speci-
fied in subsection (d)(1)(C)(iv) of such section, and
the applicable percentage increase in a hospital’s
target amount shall be deemed to be 0 percent.

“(i) TEMPORARY FREEZE IN AMOUNTS OF PAYMENT
FOR CAPITAL.—For payments attributable to portions
of cost reporting periods occurring during the exten-
sion period, the percent specified in subsection
(g)(2)(A)(i) of such section is deemed to be 3.5 per-
cent.

“(j) TEMPORARY FREEZE IN AMOUNTS OF PAYMENT
RATES FOR PPS-EXEMPT HOSPITALS.—For purposes of payment
under subsection (b) of such section for cost reporting
periods beginning during fiscal year 1988, with respect
to the first 51 days of such a period the applicable
percentage increase under paragraph (3)(B) of such
subsection is deemed to be 0 percent.’’

Notwithstanding any other provi-
sion of law, as amended by section 6216 of such Act [Pub.
L. 100–203, set out above, by section 4002(c)(2) of Pub.
L. 100–203 is effective as of Sept. 29, 1987.]

FREEZE CERTAIN CHANGES IN MEDICARE PAYMENT
REGULATIONS AND POLICIES

783, provided that:

“(1) IN GENERAL.—Notwithstanding any other provi-
sion of law, the Secretary of Health and Human Serv-
ces is not authorized to issue after September 18, 1987,
and before November 21, 1987—

“(A) any final regulation that changes the policy
with respect to payment under title XVIII of the So-
cial Security Act [this subchapter] to providers of service for reasonable costs
during the period ending on November 21, 1987, (including costs associated
with unpaid deductible and coinsurance amounts incurred under such title);

“(2) any final regulation, instruction, or other pol-
icy change which is primarily intended to have the
effect of slowing down claims processing, or delaying
payment of claims, under such title; or

“(2) any final regulation that changes the policy
under such title with respect to payment for a return
on equity capital for outpatient hospital services.

The final regulation of the Health Care Financing Ad-
ministration published on September 1, 1987 (52 Federal
Register 32529) and relating to changes to the return on
equity capital provisions for outpatient hospital serv-
cices is void and of no effect.

“(2) OTHER COST SAVINGS POLICIES.—Notwithstanding
any other provision of law, except as required to imple-
mement specific provisions required under statute, the
Secretary of Health and Human Services is not author-
ized to issue in final form, after September 18, 1987,
and before November 21, 1987, any regulation, instruction,
or other policy which is estimated by the Secretary to
result in a net reduction in expenditures under title
XVIII of the Social Security Act in fiscal year 1988 of
more than $50,000,000. Any regulation, instruction, or
policy which is issued in violation of this paragraph is
void and of no effect.

TEMPORARY EXTENSION OF PAYMENT POLICIES FOR
INPATIENT HOSPITAL SERVICES

782, as amended by Pub. L. 100–203, title IV, § 4002(c)(2), Dec. 22, 1987, 101 Stat. 1330–45, provided that: ‘‘Notwithstanding any other provision of law, with re-
spect to payment for inpatient hospital services under
section 1886 of the Social Security Act [this section]:

“(A) TEMPORARY FREEZE IN PPS HOSPITAL RATES.—
For purposes of subsection (d) of such section for dis-
charges occurring during the period beginning on Oc-
tober 1, 1987, and ending on November 20, 1987 (in this
paragraph referred to as the ‘extension period’), the
applicable percentage increase under subsection
(b)(3)(B) of such section with respect to fiscal year
1988 is deemed to be 0 percent.

“(B) TEMPORARY FREEZE IN PAYMENT BASIS.—
“(3) Exception.—Paragraphs (1) and (2) shall not be construed to apply to any regulation, instruction, or policy required to implement the amendment made by section 9311(a) of the Omnibus Budget Reconciliation Act of 1986 [section 9311(a) of Pub. L. 99–509, which amended section 1395g of this title] (relating to periodic interim payments).

MAINTAINING CURRENT OUTLINE POLICY IN FISCAL YEAR 1987

Section 9302(b)(3) of Pub. L. 99–509 provided that: ‘‘For payments made under section 1886(d) of the Social Security Act [subsec. (d) of this section] for discharges occurring in fiscal year 1987—

‘‘(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

‘‘(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.’’

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION

Section 6008(d) of Pub. L. 101–239 provided that: ‘‘Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509, set out below], shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.’’

Section 9302(d)(2) of Pub. L. 99–509 provided that: ‘‘Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act [subsec. (d)(5)(C)(i) of this section] on the date of the enactment of this Act [Oct. 21, 1986] shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.’’

BUDGET-NEUTRAL IMPLEMENTATION

Section 9302(d)(3) of Pub. L. 99–509 provided that: ‘‘Paragraph (2) [set out as a note above] and the amendment made by paragraph (1)(A) [amending this section] shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act [this section] are not reduced by reason of the classifications required by such paragraph or amendment.’’

PROMULGATION OF NEW RATE

Section 9302(f) of Pub. L. 99–509 provided that: ‘‘The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act [Oct. 21, 1986], for the publication of the payments rates that will apply under section 1886 of the Social Security Act [this section], for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section [amending this section], without regard to the provisions of chapter 5 of title 5, United States Code.’’

MISCELLANEOUS ACCOUNTING PROVISION

Section 9307(d) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, §4008(e), Dec. 22, 1987, 101 Stat. 1330–56, provided that: ‘‘Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) [set out above] with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act [Oct. 21, 1986] and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title of the Social Security Amendments of 1967 [section 402 of Pub. L. 90–248, enacting section 1395b–1 of this title and amending section 1395f of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92–665, amending sections 1395b–1 and 1395f of this title and enacting provisions set out as a note under section 1395b–1 of this title], and

‘‘(3) elects, by notice to the Secretary of Health and Human Services by not later than April 1, 1988, to have this subsection apply, during the first 7 months of such cost reporting period the ‘target percentage’ shall be 75 percent and the ‘DRG percentage’ shall be 25 percent, and during the remaining 5 months of such period the ‘target percentage’ and the ‘DRG percentage’ shall each be 50 percent.’’

‘‘(4) The Secretary shall promulgate a final rule to carry out this section, and any regulation published in violation of this section is void and of no effect.’’

TREATMENT OF CAPITAL-RELATED REGULATIONS

Section 9321(c) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, §4008(e), Dec. 22, 1987, 101 Stat. 1330–59, provided that:

‘‘(1) Prohibition of issuance of final regulations on capital-related costs as part of payment for operating costs before November 21, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before November 21, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act [part A of this subchapter]. Any regulation published in violation of this subsection is void and of no effect.

‘‘(2) Not including capital-related regulations in budget baseline.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act [subsecs. (b)(3)(B), (d)(3)(A), and (e)(4) of this section] shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

‘‘(3) Exception.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1886(v)(1)(O) of the Social Security Act [section 1395x(v)(1)(O) of this title and subsec. (g)(2) of this section] and section 1886(g)(5)(A) and (B) of the Social Security Act [subsec. (g)(5)(A) and (B) of this section] (as amended by section 393(a) of this Act).

‘‘(4) Capital-related costs defined.—In this subsection, the term ‘capital-related costs’ means those capital-related costs that are specifically excluded, under the second sentence of section 1886(a)(4) of the Social Security Act [subsec. (a)(4) of this section], from the term ‘operating costs of inpatient hospital services’ (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.

LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS

Section 9321(d) of Pub. L. 99–509 provided that: ‘‘Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) [set out above] with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act [Oct. 21, 1986] and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title
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XVIII of the Social Security Act [this subchapter] in fiscal year 1988 of more than $50,000,000, and which relates to hospitals or physicians."

STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES; REPORT TO CONGRESS

Section 910(b) of Pub. L. 99-272 provided that:

"(a) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for purposes of paragraphs (2) and (3) of section 1886(d) of the Social Security Act [subsec. (d) of this section], in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

"(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1987. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies."

CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS PARTICIPATING IN REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS

Section 910(b) of Pub. L. 99-272 provided that:

"(a) Continuation of waivers.—A hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been approved by the Secretary of Health and Human Services pursuant to section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92-603, set out as a note under section 1395b-1 of this title], or under section 402 of the Social Security Amendments of 1967 [as amended by section 222(b) of Pub. L. 92-603, set out as a note under section 1395b-1 of this title], or under section 402 of the Social Security Amendments of 1972 [section 1395b-1 of this title], shall be deemed to meet the requirements of section 1886(c)(1)(A) of the Social Security Act [subsec. (c)(1)(A) of this section] if such system applies—

"(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the geographic area served by such system on January 1, 1985, and

"(2) to the review of at least 75 percent of—

"(A) all revenues or expenses in such geographic area for inpatient hospital services, and

"(B) revenues or expenses in such geographic area for outpatient hospital services provided under the State's plan approved under title XIX [subchapter XIX of this chapter]."

"(b) APPROVAL.—In the case of a hospital reimbursement control system described in subsection (a), the requirements of section 1886(c) of the Social Security Act [subsec. (c) of this section] which apply to States shall instead apply to such system and, for such purposes, any reference to a State is deemed a reference to such system.

"(c) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS

Section 911 of Pub. L. 99-272 provided that:

"(a) Disclosure of Information.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, the Comptroller General, and the Congressional Research Service the most current information on the payment that is made under section 1886 of the Social Security Act [this section] to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

"(b) Confidentiality.—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals."

SPECIAL RULES FOR IMPLEMENTATION OF HOSPITAL REIMBURSEMENT

Section 9115 of Pub. L. 99-272 provided that:

"(a) Waiver of Paperwork Reduction.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this subpart and implementing the amendments made by this subpart [subpart A (§9110-9115) of part I of subtitle A of title IX of Pub. L. 99-272, see Tables for classification].

"(b) Use of Interim Final Regulations.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the amendments made by this subpart."

APPOINTMENT OF ADDITIONAL MEMBERS TO PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Section 9127(b) of Pub. L. 99-272, as amended by Pub. L. 100-203, title XVIII, §1896(b)(8), Oct. 22, 1986, 100 Stat. 2933, provided that: "The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a) [amending this section], no later than 60 days after the date of the enactment of this Act [Apr. 7, 1986], for terms of three years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year."

STUDIES BY SECRETARY; GAO STUDY; REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS; STUDY ON FOREIGN MEDICAL GRADUATES; ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM; PAPERWORK REDUCTION


"(c) Studies by Secretary.—(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act [this subchapter]. The study shall address—

"(A) the types and numbers of such programs, and number of students supported or trained under each program;

"(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

"(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

The Secretary shall report the results of such study to the Committee on Finance of the Senate and the Committee on Ways and Means and Energy and Commerce of the House of Representatives prior to December 31, 1987.

"(2) The Secretary shall conduct a separate study of the advisability of continuing or terminating the exception under section 1886(b)(4)(F)(ii) of the Social Security Act [subsec. (h)(4)(F)(ii) of this section] for geriatric residencies and fellowships, and of expanding such exception to cover other educational activities, particularly those which are necessary to meet the projected health care needs of Medicare beneficiaries. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics.

The Secretary shall report the results of such study to the committees described in paragraph (1) prior to July 1, 1990.

"(d) GAO Study.—(1) The Comptroller General shall conduct a study of the variation in the amounts of pay-
mements made under title XVIII of the Social Security Act [this subchapter] with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. Such study shall identify the components of such payments (including payments with respect to inpatient hospital services, physicians' services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any variations in the payment components between teaching and nonteaching settings and among different teaching settings.

"(2) In carrying out such study, the Comptroller General may utilize a sample of hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings and among teaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians' services under section 2007(c) of the Deficit Reduction Act of 1985 [section 2007(c) of Pub. L. 99–337, set out as a note under section 1395u of this title].

"(3) The Comptroller General shall report the results of the study to the committees described in subsection (c)(1) prior to December 31, 1987.

"(e) Report on uniformity of approved FTE resident amounts.—The Secretary of Health and Human Services shall report to the committees described in subsection (c)(1), not later than December 31, 1987, on whether section 1886(h) of the Social Security Act [subsection (h) of this section] should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

"(f) Study on foreign medical graduates.—The Secretary of Health and Human Services shall study, and report to the committees described in subsection (c)(1), not later than December 31, 1987, respecting the use of physicians who are foreign medical graduates (within the meaning of section 1886(h)(5)(D) of the Social Security Act [subsection (h)(5)(D) of this section]) in the provision of health care services (particularly inpatient and outpatient hospital services) to Medicare beneficiaries. Such study shall evaluate—

"(1) the types of services provided;

"(2) the cost of providing such services, relative to the cost of other physicians providing the services or other approaches to providing the services;

"(3) any deficiencies in the quality of the services provided, and methods of assuring the quality of such services; and

"(4) the impact of costs and access to services if Medicare payment for hospitals' costs of graduate medical education of foreign medical graduates were phased out.

section 1882(b)(1) of such Act [section 1395u(a)(1) of this title], shall be deemed to include the extension period.

"(c) EXTENSION PERIOD DEFINED.—

"(1) HOSPITAL PAYMENTS.—For purposes of subsection (a), the term ‘extension period’ means the period beginning on October 1, 1985, and ending on April 30, 1986.

"(2) PHYSICIAN PAYMENTS.—For purposes of subsection (a), the term ‘extension period’ means the period beginning on October 1, 1985, and ending on April 30, 1986.


DEFINITION OF HOSPITAL SERVING SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS OR PATIENTS ENTITLED TO HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED; IDENTIFICATION

Section 2315(b) of Pub. L. 98-369 provided that: ‘The Secretary of Health and Human Services shall, prior to December 31, 1984—

"(1) develop and publish a definition of ‘hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of title XVIII of the Social Security Act [subsec. (a) of this subsection] for purposes of section 1886(d)(6)(C)(i) of that Act [subsec. (d)(6)(C)(i) of this section], and

"(2) identify those hospitals which meet such definition, and make such information available to the Comptroller General of the United States, the Ways and Means of the House of Representatives, and the Committee on Finance of the Senate.’

PROSPECTIVE PAYMENT WAGE INDEX: STUDIES AND REPORTS TO CONGRESS

Section 2316 of Pub. L. 98-369, as amended by Pub. L. 99-272, title IX, §9103(a)(1), Apr. 7, 1986, 100 Stat. 156, provided that:

"(1) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act [subsec. (d) of this subsection] to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section [subsec. (d)(2)(H) and (3)(E) of this section], taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act [July 18, 1984], including any changes which the Secretary determines to be necessary to provide for an appropriate index.

"(B) The Secretary shall adjust the payment amounts for hospitals for discharges occurring on or after May 1, 1986, to reflect the changes the Secretary has promulgated in final regulations (on September 3, 1985) relating to the hospital wage index under section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section]. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage levels and relative proportions of full-time and part-time workers.

"(c) The Secretary shall conduct a study and report to the Congress on proposed criteria under which, in the case of a hospital that demonstrates to the Secretary in a current fiscal year that the adjustment being made under paragraph (2)(H) or (3)(E) of section 1886(d) of the Social Security Act [subsec. (d)(2)(H) or (3)(E) of this section] for that hospital’s discharges in that fiscal year does not accurately reflect the wage levels in the labor market serving the hospital, the Secretary, to the extent he deems appropriate, would modify such adjustment for that hospital for discharges in the subsequent fiscal year to take into account a difference in payment amounts in that current fiscal year to the hospital that resulted from such inaccuracy.’

[Section 9103(a)(2) of Pub. L. 99-272 provided that: ‘The amendment made by paragraph (1) [amending this note] shall be effective as if it had been included in the Deficit Reduction Act of 1984 (Pub. L. 98-369).’]

DIFFERENT TREATMENT OF CAPITAL-PROJECTS-RELATED COSTS BEFORE AND AFTER IMPLEMENTATION OF SYSTEM FOR INCLUDING SUCH COSTS UNDER PROSPECTIVELY DETERMINED PAYMENT RATE

Section 601(a)(3) of Pub. L. 98-21 provided that: ‘It is the intent of Congress that, in considering the implementation of a system for including capital-related costs under a prospectively determined payment rate for inpatient hospital services, costs related to capital projects for which expenditures are obligated on or after the effective date of the implementation of such a system, may or may not be distinguished and treated differently from costs of projects for which expenditures were obligated before such date.’

NEW ENGLAND HOSPITALS: CLASSIFICATION AS URBAN OR RURAL

Section 601(g) of Pub. L. 98-21 provided that: ‘In determining whether a hospital is in an urban or rural area for purposes of section 1886(d) of the Social Security Act [subsec. (d) of this section], the Secretary of Health and Human Services shall classify any hospital located in New England as being located in an urban area if such hospital was classified as being located in an urban area under the Standard Metropolitan Statistical Area system of classification in effect in 1979.’

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS RELATED TO INCLUSION IN PROSPECTIVE PAYMENT AMOUNTS OF INPATIENT HOSPITAL SERVICE CAPITAL-RELATED COSTS

Section 603(a) of title VI of Pub. L. 98-21, as amended by Pub. L. 99-369, div. B, title III, §3217, July 18, 1984, 98 Stat. 1081; Pub. L. 99-509, title IX, §9305(i)(1), Oct. 21, 1986, 100 Stat. 1993; Pub. L. 101-182, title X, §109(a)(1), Dec. 21, 1995, 109 Stat. 720, directed Secretary of Health and Human Services to report to Congress within 18 months after Apr. 20, 1983, on legislation by which capital-related costs associated with inpatient hospital services could be included within the prospective payment amounts computed under subsec. (d) of this section, further provided that the Secretary was to study and report to Congress on reimbursement of sole community hospitals based on variations in occupancy, on coordination of an information transfer between parts A and B of this subchapter, on treatment of uncompensated care costs and adjustments appropriate for large rural teaching hospitals, and on advisability of having hospitals make cost-of-care information transfers to the Secretary for patients, and further provided that the Secretary was to study and report to Congress on a method for including hospitals outside the 50 States and the District of Columbia under a prospective payment system.

INAPPLICABILITY OF COORDINATION OF FEDERAL INFORMATION POLICY TO THE COLLECTION OF INFORMATION

Section 101(b)(2)(B) of Pub. L. 97-268, as amended by Pub. L. 97-448, title III, §308(a)(1), Jan. 12, 1983, 96 Stat. 2408, provided that: ‘Chapter 35 of title 44, United States Code, shall not apply, until January 1, 1984, to collection of information and information collection requests which the Secretary of Health and Human Services determines to be necessary to carry out the amendments made by this section [amendments by section 101(a) of Pub. L. 97-268, enacting this section and amending section 1395x of this title].’

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 256b, 256c, 1320a-6, 1320a-7, 1320a-7a, 1395d, 1395e, 1395f, 1395g, 1395h, 1395i-4, 1395j, 1395l, 1395w-21, 1395w-23, 1395x, 1395y, 1395cc, 1395mm, 1395nn, 1395oo, 1395tt, 1395xx, 1395yy,
§ 1395xx. Payment of provider-based physicians and payment under certain percentage arrangements

(a) Criteria; amount of payments

(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians’ services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider’s costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.

(b) Prohibition of recognition of payments under certain percentage agreements

(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this subchapter on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider’s charges, revenues, or claim for reimbursement.

(2) Paragraph (1) shall not apply—

(A) to services furnished by a physician and described in subsection (a)(1)(B) of this section and covered by regulations in effect under subsection (a) of this section, and

(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

(i) is a customary commercial business practice, or

(ii) provides incentives for the efficient and economical operation of the provider of services.


AMENDMENTS

1983—Subsec. (a)(1)(B). Pub. L. 98–21 inserted “or on the bases described in section 1395ww 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.

EFFECTIVE DATE OF 1982 AMENDMENT

Section 109(c)(1), (2) of Pub. L. 97–248 provided that:

“(1) The amendments made by this section [amending this section and section 1395xx of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], except that section 1887(b)(1) of the Social Security Act [subsec. (b)(1) of this section] shall not apply before October 1, 1982, to services furnished by a physician and described in section 1887(a)(1)(B) of such Act [subsec. (a)(1)(B) of this section].

“(2) In the case of a contract with a provider of services entered into prior to the date of the enactment of this Act [Oct. 1, 1982], the amendment made by subsection (a) [amending this section] shall apply to payments under such contract (A) 30 days after the first date (after such date of enactment) the provider of services may unilaterally terminate the contract, or (B) one year after the date of the enactment of this Act, whichever is earlier.”

EFFECTIVE DATE OF REGULATIONS

Section 108(b), formerly §108(c), of Pub. L. 97–248, as redesignated by Pub. L. 97–448, title III, §309(a)(3), Jan. 12, 1983, 96 Stat. 2408, provided that: “The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act [subsec. (a) of this section] not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act [this subchapter] to a hospital or skilled nursing facility resulting from such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.”
§ 1395yy. Payment to skilled nursing facilities for routine service costs

(a) Per diem limitations

The Secretary, in determining the amount of the payments which may be made under this subchapter with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.

(2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.

(3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods beginning on or after October 1, 1992, on or after October 1, 1995, and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.

(b) Excess overhead allocations for hospital-based facilities

With respect to a hospital-based skilled nursing facility, the Secretary may not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations.

(c) Adjustments in limitations; publication of data

The Secretary may make adjustments in the limits set forth in subsection (a) of this section with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

(d) Access to skilled nursing facilities

(1) Subject to subsection (e) of this section, any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) and capital-related costs of extended care services provided in a cost reporting period if such facility had, in the preceding cost reporting period, fewer than 1,500 patient days with respect to which payments were made under this subchapter. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1395x(v) of this title and subsections (a) through (c) of this section and capital-related costs pursuant to section 1395x(v) of this title. This subsection shall not apply to a facility for any cost reporting period immediately following a cost reporting period in which such facility had 1,500 or more patient days with respect to which payments were made under this subchapter, without regard to whether payments were made under this subsection during such preceding cost reporting period.

(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) of this section and adjusted for different area wage levels, and

(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) of this section and adjusted for different area wage levels.

(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) of this section with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a) of this section, and the term “region” shall have the
same meaning as under section 1395ww(d)(2)(D) of this title.

(4) The Secretary shall establish the prospective payment amounts for cost reporting periods beginning in a fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a cost reporting period no later than 30 days before the beginning of that period.

(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.

(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1395x(y)(1)(E) of this title (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(e) Prospective payment

(1) Payment provision

Notwithstanding any other provision of this subchapter, subject to paragraphs (7), (11), and (12), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

(2) Definitions

For purposes of this subsection:

(A) Covered skilled nursing facility services

(i) In general

The term “covered skilled nursing facility services”—

(I) means post-hospital extended care services as defined in section 1395x(1) of this title for which benefits are provided under part A of this subchapter; and

(II) includes all items and services (other than items and services described in clauses (ii) and (iii)) for which payment may be made under part B of this subchapter and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

(ii) Services excluded

Services described in this clause are physicians’ services, services described by clauses (i) and (ii) of section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1395x(s)(2) of this title, and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

(iii) Exclusion of certain additional items and services

Items and services described in this clause are the following:

(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1395x(v)(1)(E) of this title.

(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)) and any additional chemotherapy items identified by the Secretary.

(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36645; 36823; and 96405–96542 (and as subsequently modified by the Secretary)) and any additional chemotherapy administration services identified by the Secretary.

(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)) and any additional radioisotope services identified by the Secretary.

(V) Customized prosthetic devices

(1) Commonly known as artificial limbs or components of artificial limbs under the following HCPCS codes (as of July 1, 1999, and as subsequently modified by the Secretary), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5611; L5613–L5986; L5988;
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The term “‘all costs’” means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

(C) Non-Federal percentage; Federal percentage

For—

(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the “non-Federal percentage” is 75 percent and the “Federal percentage” is 25 percent;

(ii) the next cost reporting period of such facility, the “non-Federal percentage” is 50 percent and the “Federal percentage” is 50 percent; and

(iii) the subsequent cost reporting period of such facility, the “non-Federal percentage” is 25 percent and the “Federal percentage” is 75 percent.

(D) First cost reporting period

The term “first cost reporting period” means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

(E) Transition period

(i) In general

The term “transition period” means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

(ii) Treatment of new skilled nursing facilities

In the case of a skilled nursing facility that first received payment for services under this subchapter on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

(3) Determination of facility specific per diem rates

The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

(A) Determining base payments

The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d) of this section, with appropriate adjustments (as determined by the Secretary) to non-settled cost reports or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997, and

(ii) an estimate of the amounts that would be payable under part B of this subchapter (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during the applicable cost reporting period described in clause (i) to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exemptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

(B) Update to first cost reporting period

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1.0 percentage point.

(C) Updating to applicable cost reporting period

The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility-specific update factor.

(D) Facility-specific update factor

For purposes of this paragraph, the “facility-specific update factor” for cost reporting periods beginning during—

(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility market basket percentage increase for such fiscal year minus 1 percentage point, and

(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

(4) Federal per diem rate

(A) Determination of historical per diem for facilities

For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) of this section (and facilities described in subsection (d) of this section), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjust-
ments (as determined by the Secretary) to non-settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B of this subchapter (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) Update to first fiscal year

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

(C) Computation of standardized per diem rate

The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

(ii) adjusting for variations in case mix per diem among facilities.

(D) Computation of weighted average per diem rates

(i) All facilities

The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(ii) Freestanding facilities

The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(iii) Separate computation

The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1395ww(d)(2)(D) of this title).

(E) Updating

(i) Initial period

For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted Federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

(ii) Subsequent fiscal years

The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

(II) for each of fiscal years 2001 and 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and

(III) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

(F) Adjustment for case mix creep

Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(G) Determination of Federal rate

The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

(i) Adjustment for case mix

The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

(ii) Adjustment for geographic variations in labor costs

The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by
the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

(iii) Adjustment for exclusion of certain additional items and services

The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effects under clause (ii) of paragraph (2)(A).

(H) Publication of information on per diem rates

The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

(5) Skilled nursing facility market basket index and percentage

For purposes of this subsection:

(A) Skilled nursing facility market basket index

The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

(B) Skilled nursing facility market basket percentage

The term “skilled nursing facility market basket percentage” means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(6) Submission of resident assessment data

A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1395i–3(b)(3) of this title, using the standard instrument designated by the State under section 1395i–3(e)(5) of this title.

(7) Transition for medicare swing bed hospitals

(A) In general

The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(B)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

(B) Facilities described

The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1395tt of this title, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1395f of this title (as in effect on and after such date).

(8) Limitation on review

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

(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii);

(B) the establishment of facility specific rates before July 1, 1999 (except any determination of costs paid under part A of this subchapter); and

(C) the establishment of transitional amounts under paragraph (7).

(9) Payment for certain services

In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B of this subchapter in an amount determined in accordance with section 1395l(a)(2)(B) of this title, the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service. In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A of this subchapter but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395i of this title (rather
than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(10) Required coding

No payment may be made under part B of this subchapter for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.

(11) Payment rule for certain facilities

Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).

(12) Payment rule for certain facilities

(A) In general

In the case of a qualified acute skilled nursing facility described in paragraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

(B) Facility described

For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this subchapter before July 1, 1992;

(ii) is a hospital-based facility; and

(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

(C) Description of patients

For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

(i) is entitled to benefits under part A of this subchapter; and

(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.


REFERENCES IN TEXT

Parts A and B of this subchapter, referred to in subsec. (e), are classified to 1395cc et seq. and section 1395j et seq., respectively, of this title.

AMENDMENTS

1999—Subsec. (e)(1). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(1)], substituted “subject to paragraphs (7), (11), and (12)” for “subject to paragraphs (7) and (11)” in introductory provisions.

Subsec. (e)(2)(A)(i). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(1)], substituted “items and services described in clauses (i) and (ii)” for “services described in clause (i)”.


Subsec. (e)(3)(A). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(A)], inserted “or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997 after “to non-settled cost reports”.

Subsec. (e)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(B)], substituted “furnished during the applicable cost reporting period described in clause (i)” for “furnished during such period”.

Subsec. (e)(3)(B). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(2)], added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows:

“(1) In general.—Subject to clause (i), the Secretary shall update the amount determined under subparagraph (A) for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

“(ii) Certain demonstration projects.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997.


Subsec. (e)(3)(C)(iii). Pub. L. 106–113, §1000(a)(6) [title I, §103(b)(2)], substituted “adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii)” for “(ii) adjustments for variations in labor-related costs under paragraph (4)(G)(ii)”.


Subsec. (e)(5). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(3)], inserted at end “in the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A of this subchapter but for the exclusion of such item or service under such clause, payment shall be made for the item or service in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395t of this title (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title).”
in concluding provisions.

Sec 1395k of this title.


Title VIII of the Social Security Act [this subchapter].

Amendment by section 1000(a)(6) [title III, § 321(g)(1), (k)(18)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

\[ effective under such amendments for a cost reporting period beginning on or after Oct. 1, 1993. \]

\[ after Jul. 1, 1998, see section 4432(d) of Pub. L. 105–33, or after July 1, 1998, except that amendment by section 4008(h)(2)(A)(ii) of Pub. L. 101–508 applicable to services furnished on or after Apr. 7, 1986, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1395I–3 of this title, see section 420(a) of Pub. L. 106–203, as amended, set out as an Effective Date note under section 1395d of this title.

\[ effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]. \]

\[ effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 9219(b)(1)(C) of Pub. L. 99–514, provided that: \[ "(1) The amendments made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after Oct. 1, 1986. \]

\[ effective for cost reporting periods beginning on or after Oct. 1, 1996, after Oct. 1, 1992 \]

\[ effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, or after July 1, 1998, except that amendment by section 4432(a) of Pub. L. 105–33 effective for cost reporting periods beginning on or after July 1, 1996, except that amendment by section 4432(d) applicable to items and services furnished on or after Jan. 1, 1998, see section 451(e) of Pub. L. 105–33, set out as a note under section 1395I–3 of this title. \]

\[ effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1997, Pub. L. 105–33 effective for cost reporting periods beginning on or after Oct. 1, 1993. \]

\[ effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4008(h)(2)(P) of Pub. L. 101–508, set out as a note under section 1395I–3 of this title. \]

\[ Effective Date of 1986 Amendments \]

\[ Effective Date of 1987 Amendment \]

\[ Effective Date of 1993 Amendment \]

\[ Effective Date of 1995 Amendment \]

\[ Effective Date of 1996 Amendment \]
tion 1395x of this title] and (b) [enacting this section] shall apply to cost reporting periods beginning on or after July 1, 1984.'""

REPORT TO CONGRESS

Section 4432(c) of Pub. L. 105–33 provided that: "In order to ensure that Medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section (amending this section and sections 1395i–3, 1395x, 1395y, 1395cc, and 1395tt of this title) on the quality of covered skilled nursing facility services furnished to Medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians’ services for which payment is made under Title XVIII of the Social Security Act [this subchapter]."

CONSTRUCTION OF WAGE INDEX FOR SKILLED NURSING FACILITIES

Section 13503(a)(1) of Pub. L. 103–66 provided that: "The Secretary of Health and Human Services may not provide for any change in the limits on per diem routine service costs for extended care services under section 1888 of the Social Security Act [this section] for cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendments made by paragraph (3)(A) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1888(e) of such Act to the payment limits for such services during such fiscal years."

NO CHANGE IN LIMITS ON PER DIEM SERVICE COSTS FOR EXTENDED CARE SERVICES FOR FISCAL YEARS 1994 AND 1995

Section 13503(a)(1) of Pub. L. 103–66 provided that: "The Secretary of Health and Human Services shall not apply the payment limits for such services during such fiscal years."

NO CHANGE IN PROSPECTIVE PAYMENTS FOR SERVICES FURNISHED DURING FISCAL YEARS 1994 AND 1995

Section 13503(b) of Pub. L. 103–66 provided that: "The Secretary of Health and Human Services may not change the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act [subsec. (d) of this section] for services furnished during cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendment made by subsection (c)(1)(A) [amending section 1395x of this title]."

PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES

Section 4008(k) of Pub. L. 101–508 provided that: "(1) DEPARTMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A (part A of this subchapter) of the Medicare program to develop such a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

(B) provide for adjustments to prospectively determined rates to account for changes in a facility’s case mix, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patient, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

(2) REPORTS.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committees on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives."

USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES

Pub. L. 101–239, title VI, § 6024, Dec. 19, 1989, 103 Stat. 2167, as amended by Pub. L. 101–508, title IV, § 4008(e)(1), Nov. 5, 1990, 104 Stat. 1338–23, provided that: "The Secretary of Health and Human Services shall determine a mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act [subsec. (a) of this section] for cost reporting periods beginning after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning after October 1, 1985. The Secretary shall update such costs under such section for cost reporting periods beginning on or after October 1, 1989, by using cost reports submitted by skilled nursing facilities for cost reporting periods ending not earlier than January 31, 1988, and not later than December 31, 1988."
SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1395(i), 1395j, 1395k, 1395x, 1395y, 1395cc, 1395tt of this title.


EFFECTIVE DATE OF REPEAL

Repeal effective as if included in the enactment of Pub. L. 101–508, see section 171(i) of Pub. L. 103–432, set out as an Effective Date of 1994 Amendment note under section 1395ss of this title.

§ 1395aaa. Transferred

CODIFICATION


§ 1395bbb. Conditions of participation for home health agencies; home health quality

(a) Conditions of participation; protection of individual rights; notification of State entities; use of home health aides; medical equipment; individual’s plan of care; compliance with Federal, State, and local laws and regulations

The conditions of participation that a home health agency is required to meet under this subsection are as follows:

(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual’s well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

(C) The right to confidentiality of the clinical records described in section 1395x(o)(3) of this title.

(D) The right to have one’s property treated with respect.

(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this subchapter,

(ii) the coverage available for such items and services under this subchapter, subchapter XIX of this chapter, and any other Federal program of which the agency is reasonably aware,

(iii) any charges for items and services not covered under this subchapter and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

(F) The right to be fully informed of the availability of the State home health agency hotline established under section 1395aa(a) of this title.

(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

(A) the persons with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the agency

(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a–5(b) of this title) of the agency, and

(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual to provide items or services described in section 1395x(m) of this title on or after January 1, 1990, unless the individual—

(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a com-
petency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1395x(m) of this title for compensation.

(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1988, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

(ii) The agency must provide such regular performance review and regular in-service education as assures that individuals used to provide items and services described in section 1395x(m) of this title are competent to provide those items and services.

(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on December 22, 1987, except that they may not provide for the approval of a program offered by or in a home health agency which, within the previous 2 years—

(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D) of this section;

(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of this section of not less than $5,000; or

(IV) has been subject to the remedies described in subsection (e)(1) of this section or in clauses (ii) or (iii) of subsection (f)(2)(A) of this section.

(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1988) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

(E) In this paragraph, the term “home health aide” means any individual who provides the items and services described in section 1395x(m) of this title, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (F)), or

(ii) who volunteers to provide such services without monetary compensation.

(F) In this paragraph, the term “licensed health professional” means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(4) The agency includes an individual’s plan of care required under section 1395x(m) of this title as part of the clinical records described in section 1395x(o)(3) of this title.

(5) The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

(6) The agency complies with the requirements of section 1395ccc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(b) Duty of Secretary

It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1395x(o) of this title and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.

(c) Surveys of home health agencies

(1) Any agreement entered into or renewed by the Secretary pursuant to section 1395aa of this title relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a of this title. The Secretary shall review each State’s or local agency’s procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval
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commensurate with the need to assure the delivery of quality home health services.

(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1395aa(a) of this title), or any other appropriate Federal, State, or local agency.

(C) A standard survey conducted under this paragraph with respect to a home health agency—

(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d) of this section) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1395x(m) of this title and clinical records required under section 1395x(o)(2) of this title; and

(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section, and

(III) who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) of this section on the basis of the findings of a standard survey.

(d) Assessment process; reports to Congress

(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(i) of this section.

(2)(A) Not later than January 1, 1992, the Secretary shall—

(i) evaluate the assessment process,

(ii) report to Congress on the results of such evaluation, and

(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).

(e) Enforcement

(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter no longer is in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) of this section or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A) of this section.

(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter no longer is in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section and determines that the deficiencies involved do not immediately jeopardize the health

1 So in original. Probably should be subsection "c(2)(C)(i)(D)".
and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f) of this section, in lieu of terminating the certification of the agency. If, after such a period of intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section, the Secretary shall terminate the certification of the agency.

(3) If the Secretary determines that a home health agency that is certified for participation under this subchapter is in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection (f)(2)(A)(i) of this section for the days in which it finds that the agency was not in compliance with such requirements.

(4) The Secretary may continue payments under this subchapter with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the agency with the requirements than to terminate the certification of the agency,

(B) the agency has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the agency agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective action requested by home health agencies under this subparagraph.

(f) Intermediate sanctions

(1) The Secretary shall develop and implement, by not later than April 1, 1989—

(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e) of this section, and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance,

(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this subchapter with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2) of this section, and

(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section.

The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under subsection (a) of this title. The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1395x(o) of this title and subsection (a) of this section.

(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(g) Payment on basis of location of service

A home health agency shall submit claims for payment for home health services under this subchapter only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

Amendments


1996—Subsec. (c)(2)(A). Pub. L. 104–134 substituted “36 months” for “15 months” in first sentence and amended...
last sentence generally. Prior to amendment, last sentence read as follows: “The statewide average interval between standard surveys of any home health agency shall not exceed 12 months.”


Subsec. (a)(4) to (6). Pub. L. 100–360, § 411(d)(3)(A)(iii), redesignated pars. (5) and (6) as (4) and (5), respectively, and struck out former par. (4) which read as follows: “With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment do not use (on a full-time, temporary, per diem, or other basis) any individual who does not meet minimum training standards (established by the Secretary by October 1, 1988) for the demonstration and use of such equipment furnished to individuals with respect to whom payment may be made under this subchapter.”

Subsec. (c)(1). Pub. L. 100–360, § 411(d)(2)(A), as amended by Pub. L. 100–465, § 689(d)(2)(A), amended third sentence generally. Prior to amendment, third sentence read as follows: “The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1220a–7a of this title.”


Effective Date of 1988 Amendments


Except as specifically provided in section 411 of Pub. L. 100–360, amendment made by Pub. L. 100–360, as amended by Pub. L. 100–485, effective as if included in the enactment of that provision in Pub. L. 100–360, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Effective Date of 1987 Amendment

Section 4022(b) of Pub. L. 100–203 provided that: “Except as otherwise specifically provided in section 1891(d) of the Social Security Act [subsec. (d) of this section] (as added by subsection (a) of this section) shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987].”

Section 4022(b) of Pub. L. 100–203, as amended by Pub. L. 100–360, title IV, § 411(d)(3)(C), July 1, 1988, 102 Stat. 774, provided that: “Except as otherwise specifically provided in subsections (e) and (f) of section 1891 of the Social Security Act [subsecs. (e) and (f) of this section] (as added by subsection (a) of this section) shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987], and no intermediate sanction described in section 1891(f)(2)(A) of such Act [subsec. (f)(2)(A) of this section] shall be imposed for violations occurring before such effective date.”
§ 1395cc. Offset of payments to individuals to collect past-due obligations arising from breach of scholarship and loan contract

(a) In general

(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this section with any individual who, by reason of a breach of a contract entered into by such individual pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program, owes a past-due obligation to the United States (as defined in subsection (b) of this section).

(B) The Secretary shall not enter into an agreement with an individual under this section to the extent—

(i)(I) the individual has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987, and

(ii) the liability of the individual under such section 204(a)(1) has otherwise been relieved under such section; or

(iii) the individual is performing such physician's service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.).

(2) The agreement under this section shall provide that—

(A) deductions shall be made from the amounts otherwise payable to the individual under this subchapter, in accordance with a formula and schedule agreed to by the Secretary and the individual, until such past-due obligation (and accrued interest) have been repaid;

(B) payment under this subchapter for services provided by such individual shall be made only on an assignment-related basis;

(C) if the individual does not provide services, for which payment would otherwise be made under this subchapter, of a sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(ii) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(3) If the individual refuses to enter into an agreement or breaches any provision of the agreement—

(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(B) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(4) The Secretary shall not exclude an individual pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such individual is a sole community practitioner or sole source of essential specialized services in a community if a State requests that the individual not be excluded.

(b) Past-due obligation

For purposes of this section, a past-due obligation is any amount—

(1) owed by an individual to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act (42 U.S.C. 254e) or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section, and has not been canceled, waived, or suspended by the Secretary pursuant to such section; or

(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.

(c) Collection under this section shall not be exclusive

This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31 and the application of other procedures provided under chapter 37 of title 31.

(d) Collection from providers and health maintenance organizations

(1) In the case of an individual who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1395ccc of this title or a health maintenance organization or competitive medical plan having a contract under section 1395f of this title or section 1395mm of this title, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this subchapter to such provider, organization, or plan.

(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the individual and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the individual under this subchapter as long as the individual continues to be employed or affiliated by a medical services agreement.

(3) Such deduction shall not be made until 6 months after the Secretary notifies the pro-
vider, organization, or plan of the amount to be deducted and the particular physicians to whom the deductions are attributable.

(4) A deduction made under this subsection shall relieve the individual of the obligation (to the extent of the amount collected) to the United States, but the provider, organization, or plan shall have a right of action to collect from such individual the amount deducted pursuant to this subsection (including accumulated interest).

(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the individual pays the past-due obligation, or causes to be employed by the provider, organization, or plan.

(6) The Secretary shall also apply the provisions of this subsection in the case of an individual who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.

(e) Transfer from trust funds

Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.


REFERENCES IN TEXT


The Public Health Service Act, referred to in subsecs. (a)(1)(B)(i) and (b), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Subpart II of part D of title III of the Act is classified generally to subpart II (§ 254d et seq.) of part D of subchapter II of chapter 6A of this title.


Subpart III of part F of title VII of the Public Health Service Act (as in effect before October 1, 1976) was classified to subpart III (§ 295g–21 et seq.) of part F of subchapter V of chapter 6A of this title, prior to repeal by Pub. L. 94–444, title IV, § 409(a), Oct. 12, 1976, 90 Stat. 2290. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS


Pub. L. 100–360, § 411(f)(10)(A)(III), as amended by Pub. L. 100–360, § 608(d)(21)(E), inserted before period at end “if a State requests that the individual not be excluded”.

Pub. L. 100–360, § 411(f)(10)(A)(II), substituted “exclude” for “bar”.

Subsec. (b). Pub. L. 100–360, § 411(f)(10)(C)(V), as amended by Pub. L. 100–485, § 608(d)(21)(F)(i), substituted “or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976)” which has not been paid by the deadline established by the Secretary pursuant to such respective section for “if”, and (2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act”.


EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 698(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(10)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, ef-
of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities.

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement; and

(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5) of this section, an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1395u of this title.

(d) Process for entering into contracts

The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1395h of this title or contracts under section 1395u of this title in effect on August 21, 1996.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor’s liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

References in Text

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec.
(d)(2)(B), is section 202(b) of Pub. L. 104–191, which amended sections 1395h and 1395u of this title.

SECTION REFERRED TO IN OTHER SECTIONS
This section is referred to in sections 1395h, 1395i, 1395s of this title.

§ 1395eee. Payments to, and coverage of benefits under, programs of all-inclusive care for elderly (PACE)

(a) Receipt of benefits through enrollment in PACE program; definitions for PACE program related terms

(1) Benefits through enrollment in a PACE program

In accordance with this section, in the case of an individual who is entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this subchapter solely through such program; and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) “PACE program” defined

For purposes of this section, the term “PACE program” means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual’s medical records available to new providers.

(3) “PACE provider” defined

(A) In general

For purposes of this section, the term “PACE provider” means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h) of this section; and

(ii) after the date the report under section 4004(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) “PACE program agreement” defined

For purposes of this section, the term “PACE program agreement” means, with respect to a PACE provider, an agreement, consistent with this section, section 1395u–4 of this title (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) “PACE program eligible individual” defined

For purposes of this section, the term “PACE program eligible individual” means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4) of this section, is determined under subsection (c) of this section to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii) of this section.

(6) “PACE protocol” defined

For purposes of this section, the term “PACE protocol” means the Protocol for the Program of All-Inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) “PACE demonstration waiver program” defined

For purposes of this section, the term “PACE demonstration waiver program” means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).
(8) “State administering agency” defined

For purposes of this section, the term “State administering agency” means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under subchapter XIX of this chapter in the State) responsible for administering PACE program agreements under this section and section 1396u–4 of this title in the State.

(9) “Trial period” defined

(A) In general

For purposes of this section, the term “trial period” means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) “Regulations” defined

For purposes of this section, the term “regulations” refers to interim final or final regulations promulgated under subsection (f) of this section to carry out this section and section 1396u–4 of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals enrolled with the provider, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under this subchapter (for individuals enrolled under this section) and all items and services covered under subchapter XIX of this chapter, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, co-payments, coinsurance, or other cost-sharing that would otherwise apply under this subchapter or such subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law that are designed for the protection of patients.

(c) Eligibility determinations

(1) In general

The determination of whether an individual is a PACE program eligible individual—

(A) shall be made under and in accordance with the PACE program agreement; and

(B) who is entitled to medical assistance under subchapter XIX of this chapter, shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual’s health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential PACE program eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) of this section for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual’s condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to
be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) of this section if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and section 1396u–4 of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term “noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed voluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+ Choice organization under section 1395w–23 of this title (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1395mm of this title). Such payments shall be subject to adjustment in the manner described in section 1395w–23(a)(2) of this title or section 1395mm(a)(1)(E) of this title, as the case may be.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1395w–23 of this title (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1395mm of this title) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this subchapter for a comparable population not enrolled under a PACE program.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1396u–4 of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of August 5, 1997; or

(II) as of each succeeding anniversary of August 5, 1997, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h) of this section; or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii) of this section.

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program—
(i) shall designate the service area of the program;
(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;
(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);
(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and
(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9) of this section) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an on-site visit to the program site;
(ii) comprehensive assessment of the provider’s fiscal soundness;
(iii) comprehensive assessment of the provider’s capacity to provide all PACE services to all enrolled participants;
(iv) detailed analysis of the entity’s substantial compliance with all significant requirements of this section and regulations; and
(v) any other elements the Secretary or State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider’s program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and
(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) there are significant deficiencies in the quality of care provided to enrolled participants; or
(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1396u–4 of this title; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C) of this section.

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1396a–4 of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1395w–27(g)(2) (or, for periods before January 1, 1999, section 1395mm(i)(6)(B) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in section 1395w–27(g)(1) (or section 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396a–4 of this title, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of section 1395w–27(h) of this title (or for periods before January 1, 1999, section 1395mm(i)(9) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of this subchapter (or for such periods an eligible organization under section 1395mm of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and section 1396u–4 of this title.

(2) Use of PACE protocol

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1396u–4 of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long-term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of this subchapter (or for periods before January 1, 1999, section 1395mm of this title) and sections 1396b(m) and 1396u–2 of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part C.
of this subchapter (or for such periods eligible organizations under risk-sharing contracts under section 1396mm of this title) and to medicaid managed care organizations under prepaid capitation agreements under section 1396b(m) of this title.

(b) Considerations

In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C of this subchapter (or, for periods before January 1, 1999, section 1395m of this title) and section 1396b(m) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XIX of this chapter.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1395d of this title, insofar as it limits coverage of institutional services.

(2) Sections 1395e, 1395f, 1395l, and 1395ww of this title, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1395f(a)(2)(B), 1395f(a)(2)(C), and 1395m(a)(2)(A) of this title, insofar as they limit coverage of extended care services or home health services.

(4) Section 1395s(i) of this title, insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Paragraphs (1) and (9) of section 1395y(a) of this title, insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) of this section that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B) of this section.

(i) Miscellaneous provisions

Nothing in this section or section 1396u-4 of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A of this subchapter, or enrolled under part B of this subchapter, or eligible for medical assistance under subchapter XIX of this title.


REFERENCES IN TEXT

Parts A, B, and C of this subchapter, referred to in subsecs. (a)(1), (e)(7), (f)(3), and (i), are classified to sections 1395c et seq., 1395d et seq., and 1395w–21 et seq., respectively, of this title.


Section 4804(b) of the Balanced Budget Act of 1997, referred to in subsec. (a)(3)(B)(ii), is section 4804(b) of Pub. L. 105–33, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (a)(7)(A), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.


For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set out below.

TRANSITION; REGULATIONS

Section 4803 of title IV of Pub. L. 105–33 provided that—

"(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle [subtitle I (§§4801–4808) of title IV of Pub. L. 105–33], enacting this section and section 1396u–4 of this title, amending sections 1396b, 1396d, 1396k–5, and 1396v of this title, and enacting provisions set out as notes under this section and section 1395w–6 of this title] in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1394 and 1394 of the Social Security Act (this section and section 1396u–4 of this title) (as added by sections 4801 and 4802 of this subtitle) for periods beginning not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997]."
“(b) Expansion and Transition for PACE Demonstration Project Waivers.—

(1) Expansion in current number and extension of demonstration projects.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (see subsection (d) below), as amended by section 1118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) In paragraph (1), by inserting before the period at the end the following: ‘, except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in sections 1894(e)(1)(B) and 1934(e)(1)(B) of the Social Security Act’ (subsection (e)(1)(B) of this section and section 1396u–5(c)(1)(B) of this title); and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ‘, including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk’; and

(ii) in subparagraph (C), by adding at the end the following: ‘; in granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.’

(2) Elimination of replication requirement.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act [Aug. 5, 1997].

(3) Timely Consideration of Applications.—In considering an application for waivers under such section before the effective date of the repeal under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(4) Priority and Special Consideration in Application.—During the 3-year period beginning on the date of the enactment of this Act [Aug. 5, 1997]:

(1) Provider Status.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1934 of the Social Security Act (title XVIII and section 1396d-4 of this title)—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in sections 1894(a)(7) and 1934(a)(7) of such Act (subsection and section 1396u–4(a)(7) of this title)); and

(B) then to entities that have applied to operate such a program as of May 1, 1997.

(2) New waivers.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (see subsection (d) below)—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(5) Special consideration.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which, as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(6) Repeal of current PACE demonstration project waiver authority.—

(1) In general.—Subject to paragraph (2), the following provisions of law are repealed:—

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21) [97 Stat. 181].

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) [100 Stat. 118].

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) [100 Stat. 2062].

(2) Delay in application to current waivers.—

(A) In general.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before the initial effective date of regulations described in subsection (a), the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 24 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396d–4 of this title and amending sections 1396b, 1396d, 1396–5, and 1396v of this title].

(B) State option to seek extension of current period.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act [Aug. 5, 1997]) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 3 years after the initial effective date of regulations described in subsection (a). If a State makes such an election, the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs.

PACE Programs: Study and Reports

Section 4803(a), (b) of title IV of Pub. L. 105–33 provided that—

(a) Study.—

(1) In general.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act [subsection (a)(8) of this section and section 1396u–4(a)(8) of this title]) shall conduct a study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396d–4 of this title and amending sections 1396b, 1396d, 1396–5, and 1396v of this title].

(2) Study of private, for-profit providers.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act [subsection (b) of this section and section 1396u–4(h) of this title] with the costs, quality, and access to services of other PACE providers.

(b) Report.—

(1) In general.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) Treatment of private, for-profit providers.—The report shall include specific findings on whether any of the following findings is true:—
“(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 900 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

“(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

“(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

“(D) The application of such section has resulted in an increase or expenditures under the Medicare or Medicaid programs above the expenditures that would have been made if such section did not apply.”

Section referred to in Other Sections

This section is referred to in sections 1395ss, 1396r–5, 1396a–4 of this title.

§ 1395fff. Prospective payment for home health services

(a) In general

Notwithstanding section 1395x(v) of this title, the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) System of prospective payment for home health services

(1) In general

The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the Medicare home health benefit as of August 5, 1997, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) Reduction

The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits are in effect on September 30, 2000.

(B) Annual update

(i) In general

The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2002) in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year involved.

(ii) Home health applicable increase percentage

For purposes of this subparagraph, the term “home health applicable increase percentage” means, with respect to—

(I) each of fiscal years 2002 and 2003, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points; or

(II) any subsequent fiscal year, the home health market basket percentage increase.
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| (iii) Home health market basket percentage increase |
| For purposes of this subsection, the term “home health market basket percentage increase” means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1395ww(b)(3)(B)(iii) of this title is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year. |

| (C) Adjustment for outliers |
| The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers). |

| (4) Payment computation |
| (A) In general |
| The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows: |
| (i) Case mix adjustment |
| The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)). |
| (ii) Area wage adjustment |
| The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify. |

| (B) Establishment of case mix adjustment factors |
| The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services. |

| (C) Establishment of area wage adjustment factors |
| The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1395ww(d)(3)(E) of this title. |

| (5) Outliers |
| The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year. |

| (6) Proration of prospective payment amounts |
| If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved. |

| (c) Requirements for payment information |
| With respect to home health services furnished on or after October 1, 1998, no claim for services furnished under this paragraph applicable to home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary before the beginning of the fiscal year. |

| (d) Limitation on review |
| There shall be no administrative or judicial review under section 1395fff of this title, 1395es of this title, or otherwise of— |
| (1) the claim has the unique identifier (provided under section 1395u(r) of this title) for the physician who prescribed the services or made the certification described in section 1395f(a)(2) or 1395m(a)(2)(A) of this title; and |
| (2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1395(m) of this title, the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments. |

AMENDMENTS
Subsec. (b)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §302(b)], amended heading and text of cl. (i) gener-
ally. Prior to amendment, text read as follows: "Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (i) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4(A)). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area."

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(1)], which directed that the second sentence of cl. (i) be amended in subcl. (I) by the insertion of "and if section 1395x(v)(1)(L)(ix) of this title had not been enacted" before semicolon, was executed by making the insertion before the period at the end of subcl. (I) to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(2)], inserted "and if section 1395x(v)(1)(L)(ix) of this title had not been enacted after "if the system had not been in effect".


1998—Subsec. (a). Pub. L. 105–277, §5101(c)(1)(A), substituted "for portions of cost reporting periods occurring on or after October 1, 2000" for "for fiscal cost reporting periods beginning on or after October 1, 1998".


Subsec. (b)(3)(B)(i). Pub. L. 105–277, §5101(d)(2)(A), substituted "home health applicable increase percentage (as defined in clause (ii))" for "home health market basket percentage increase".


\section{Adjustment To Reflect Administrative Costs Not Incurred in the Employment Payment System; GAO Report on Costs of Compliance With OASIS Data Collection Requirements}


\subsection{Adjustment To Reflect Administrative Costs Not Incurred in the Employment Payment System}


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means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the Medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient’s current status and that incorporates the Outcome and Assessment Information Set (OASIS).

“(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term ‘Outcome and Assessment Information Set’ means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.”

REPORT TO CONGRESS ON NEED FOR REDUCTIONS

“(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as ‘MedPAC’) shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for home health services established under such section.”

STUDY AND REPORT TO CONGRESS REGARDING EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

“(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as ‘MedPAC’) shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for home health services established under such section.”

CASE MIX SYSTEM DEVELOPMENT
Section 462(d) of Pub. L. 105–33 provided that: “The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the Medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjustor that explains a significant amount of the variances in costs.”

CASE MIX SYSTEM; SUBMISSION OF DATA
Section 462(e) of Pub. L. 105–33 provided that: “Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.”

PROSPECTIVE PAYMENT SYSTEM CONTINGENCY

“if the Secretary of Health and Human Services did not establish and implement the prospective payment system for home health services described in subsection (b) of this section for portions of cost reporting periods described in section 463(d) of Pub. L. 105–33 (set out as a note above), for such portions the Secretary was to provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits would otherwise have been in effect on Sept. 30, 2000, prior to repeal by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §302(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359.

REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT
Section 4616 of Pub. L. 105–33 provided that:

“(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act [parts A and B of this subchapter] for the provision of home health services during each of fiscal years 1998 through 2002.

“(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the Medicare program or such other methods as will reduce the growth in outlays for home health services under the Medicare program.”

SECTION REFERRED TO IN OTHER SECTIONS
This section is referred to in sections 1395f, 1395l, 1395r of this title.

§1395ggg. Medicare subvention demonstration project for military retirees

(a) Definitions
In this section:

(1) Administering Secretaries
The term “administering Secretaries” means the Secretary and the Secretary of Defense acting jointly.

(2) Demonstration project; project
The terms “demonstration project” and “project” mean the demonstration project carried out under this section.

(3) Designated provider
The term “designated provider” has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

(4) Medicare-eligible military retiree or dependent
The term “medicare-eligible military retiree or dependent” means an individual described in section 1074(b) or 1076(b) of title 10 who—

(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086; and

(B) is entitled to benefits under part A of this subchapter; and
(ii) if the individual was entitled to such benefits before July 1, 1997, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this subchapter; and
(C) is enrolled for benefits under part B of this subchapter; and
(D) has attained age 65.

(5) Medicare health care services
The term “medicare health care services” means items or services covered under part A or B of this subchapter.

(6) Military treatment facility
The term “military treatment facility” means a facility referred to in section 1074(a) of title 10.

(7) TRICARE
The term “TRICARE” has the same meaning as the term “TRICARE program” under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

(8) Trust funds
The term “trust funds” means the Federal Hospital Insurance Trust Fund established in section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund established in section 1395t of this title.

(b) Demonstration project
(1) In general
(A) Establishment
The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider.

(B) Agreement
The agreement entered into under subparagraph (A) shall include at a minimum—
(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;
(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements;
(iii) a description of how the demonstration project will satisfy the requirements under this subchapter;
(iv) a description of the sites selected under paragraph (2);
(v) a description of how reimbursement requirements under subsection (i) of this section and maintenance of effort requirements under subsection (j) of this section will be implemented in the demonstration project;
(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project;
(vii) a description of any requirement that the Secretary waives pursuant to subsection (d) of this section; and
(viii) a certification, provided after review by the administering Secretaries, that any entity that is receiving payments by reason of the demonstration project has sufficient—
(I) resources and expertise to provide, consistent with payments under subsection (i) of this section, the full range of benefits required to be provided to beneficiaries under the project; and
(II) information and billing systems in place to ensure the accurate and timely submission of claims for benefits and to ensure that providers of services, physicians, and other health care professionals are reimbursed by the entity in a timely and accurate manner.

(2) Number of sites
The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

(3) Restriction
No new military treatment facilities will be built or expanded with funds from the demonstration project.

(4) Duration
The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

(5) Report
At least 60 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) to the committees of jurisdiction under this subchapter.

(c) Crediting of payments
A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

(d) Waiver of certain medicare requirements
(1) Authority
Except as provided under subparagraph (B), the demonstration project shall meet all requirements of Medicare+Choice plans under part C of this subchapter and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1395(c) and 1395n(d) of this title, and para-
§ 1395g

graphs (2) and (3) of section 1395y(a) of this title shall not apply.

(B) Waiver

Except as provided in paragraph (2), the Secretary is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

(i) reflects the unique status of the Department of Defense as an agency of the Federal Government; and

(ii) is necessary to carry out the demonstration project.

(2) Beneficiary protections and other matters

The demonstration project shall comply with the requirements of part C of this subchapter that relate to beneficiary protections and other matters, including such requirements relating to the following areas:

(A) Enrollment and disenrollment.

(B) Nondiscrimination.

(C) Information provided to beneficiaries.

(D) Cost-sharing limitations.

(E) Appeal and grievance procedures.

(F) Provider participation.

(G) Access to services.

(H) Quality assurance and external review.

(I) Advance directives.

(J) Other areas of beneficiary protections that the Secretary determines are applicable to such project.

(e) Inspector General

Nothing in the agreement entered into under subsection (b) of this section shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this subchapter for the demonstration project, including compliance with the provisions of this subchapter and all other relevant laws.

(f) Voluntary participation

Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary.

(g) TRICARE health care plans

(1) Modification of TRICARE contracts

In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts (including contracts with designated providers) in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project consistent with part C of this subchapter.

(2) Health care benefits

The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this subchapter.

(h) Additional plans

Notwithstanding any provisions of title 10, the administering Secretaries may agree to include in the demonstration project any of the Medicare+Choice plans described in section 1395w–21(a)(2)(A) of this title, and such agreement may include an agreement between the Secretary of Defense and the Medicare+Choice organization offering such plan to provide medicare health care services to medicare-eligible military retirees or dependents and for such Secretary to receive payments from such organization for the provision of such services.

(i) Payments based on regular medicare payment rates

(1) In general

Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this subchapter with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary shall establish rules for computing equivalent or comparable payment amounts.

(2) Exclusion of certain amounts

In computing the amount of payment under paragraph (1), the following shall be excluded:

(A) Special payments

Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1395ww(d)(5) of this title and subsection (b) of such section.

(B) Percentage of capital payments

An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

(3) Periodic payments from medicare trust funds

Payments under this subsection shall be made—

(A) on a periodic basis consistent with the periodicity of payments under this subchapter; and

(B) in appropriate part, as determined by the Secretary, from the trust funds.

(4) Cap on amount

The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) of this section shall not exceed a total of—

(A) $50,000,000 for calendar year 1998;

(B) $60,000,000 for calendar year 1999; and

(C) $65,000,000 for calendar year 2000.

(j) Maintenance of effort

(1) Monitoring effect of demonstration program on costs to medicare program

(A) In general

The administering Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project com-
pared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) of this section shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

(B) Annual report by the Comptroller General

Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the administering Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this subchapter increased during the preceding fiscal year as a result of the demonstration project.

(2) Required response in case of increase in costs

(A) In general

If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this subchapter increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

(i) to recoup for the medicare program the amount of such increase in expenditures; and

(ii) to prevent any such increase in the future.

(B) Steps

Such steps—

(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

(ii) under subparagraph (A)(ii) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under subsection (i)(1) of this section.

(k) Evaluation and reports

(1) Independent evaluation

The Comptroller General of the United States shall conduct an evaluation of the demonstration project, and shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 5 1/2 years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b) of this section, of the following:

(A) Any savings or costs to the medicare program under this subchapter resulting from the demonstration project.

(B) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

(C) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

(D) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

(E) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

(F) Compliance by the Department of Defense with the requirements under this subchapter.

(G) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this subchapter).

(H) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

(I) Any impact of the demonstration project on private health care providers and beneficiaries under this subchapter that are not enrolled in the demonstration project.

(J) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

(K) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

(L) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this subchapter.

(M) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project and TRICARE contracts.

(N) Any additional elements specified in the agreement entered into under subsection (b) of this section.

(O) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the demonstration project.
§ 1396. Appropiations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitative and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.


Amendments


Effective Date of 1984 Amendment

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which was due (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

Effective Date of 1973 Amendment

Amendment by Pub. L. 93-233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as a note under section 1396a of this title.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance shall consist of—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter;

July 1, 1969, for payment under this subchapter.

1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance shall consist of—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter;